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ADOLESCENTS' PERCEPTIONS OF THE ESSENTIAL THERAPEUTIC PROCESSES AND TREATMENT INGREDIENTS IN AN EFFECTIVE RESIDENTIAL TREATMENT PROGRAM FOR EMOTIONALLY DISTURBED ADOLESCENTS: A GROUNDED THEORY APPROACH

BY

DENNIS H. BROWN ©

A THESIS
SUBMITTED TO THE FACULTY OF GRADUATE STUDIES AND RESEARCH
IN PARTIAL FULFILLMENT OF THE REQUIREMENTS FOR
THE DEGREE OF DOCTOR OF PHILOSOPHY

IN

COUNSELLING PSYCHOLOGY

DEPARTMENT OF EDUCATIONAL PSYCHOLOGY

EDMONTON, ALBERTA

(FALL 1991)

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DEDICATION

To Dr. B., the staff, and the kids
at CASE House
who have taught me so much about healing
troubled hearts and minds,
and to
Dr. Ken Grierson and Karen Sharpe,
who have reminded me about the real priorities of life.

ABSTRACT

This study was concerned with the residential treatment of emotionally disturbed adolescents. This form of treatment can be viewed as both a social solution and a treatment modality. Understanding of it as a treatment modality is far from complete, particularly the understanding of the therapeutic processes necessary to successfully treat emotionally disturbed adolescents. The present study was designed with this problem in mind. Guided by grounded theory methodology, this study utilized the perceptions of adolescents who had undergone treatment at an adolescent residential treatment center to generate a data-based theory about effective residential treatment. Based on the perceptions of successful adolescents, this study identified two basic social psychological processes (BSPPs) - Doing Your Work and Being Helped - that appeared to be important to successful long-term outcome. Two substantive theories - one on working, the other on being helped - were generated from the findings in this study. These two theories outlined the key stages adolescents go through and the primary tasks they undertake as they undergo treatment in an adolescent residential treatment center. The findings of this study, along with relevant findings from the professional literature, were then integrated into a more formal substantive theory on working and being helped. It is suggested in this theory that there are three important

components - tasks, working environment and relationships - that must be managed effectively in order for parties to reach desired goals. It is also suggested that in order for parties to attain mutually desired goals they must collaborate together. It is hoped that this more generic theory can be used to benefit both those involved in residential treatment and those involved in situations where people are trying to achieve goals and are being helped by others to do this.

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It is one thing to hear people say that a dissertation is the result of the cumulative efforts of many people; it is another matter entirely to experience firsthand the process of being encouraged and assisted by so many people to transform a vague abstraction into a tangible reality. Having experienced this process, I now find that making these acknowledgements is one of the most enjoyable tasks of writing this dissertation.

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thank the dedicated staff at CASA House for their encouragement, patience, and tolerance over the many past months.

Although I began this project with some interesting ideas and questions, I would have long ago abandoned it without the superb guidance from the members of my supervisory committee. All gave generously of their time and of themselves to help me turn intriguing questions into useful results. Dr. Don Sawatzky helped me formulate my beginning research questions and then guided me through all of the major steps that are encountered in doing a dissertation. He struck the right balance between giving me enough direction to allay my anxiety and giving me enough freedom to make my own mistakes. Dr. Marilyn Assheton-Smith not only patiently guided me through the frustrations of learning and using a new methodology, but also encouraged me during those "darker times" that are an inevitable part of a research project. Dr. Todd Rogers in many ways served as my conscience during this project. Often, I found myself saying "Yes, but what would Dr. Rogers say to this?" I know his scholarship and committment to "disciplined inquiry" will continue to inspire me long after I have completed this project. The members of my examining committee, Dr. Paul Sartoris, Dr. David Wangler, and Dr. Frank Van Hesteren provided excellent models of professional competency by blending personal warmth with rigorous scholarship, something which was a particular accomplishment for Dr. Van Hesteren, my external adviser, because we never met in person.

While the responsibility for the printed material in this document is mine, the actual writing of this report could not have been accomplished without the initial guidance of Dorothy Zolf-McDonald, Ph.D., the constructive comments of Bruce Grierson, and the ongoing and tireless assistance of Henry Johnson. Along with the members of my supervisory committee, these people helped turn awkward ideas into readable sentences. A special thanks must go to Henry for his cheerful help during those "blitzkreig" library searches and seemingly endless rewritings. A special thanks must also go to Litwina Dory, my typist, who patiently typed numerous drafts of this document. While I labored to give "birth" to a dissertation, Litwina went one better and gave birth to a daughter, and then, amidst feedings and diapers, managed to help bring this document into the world.

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CHAPTER ONE

STATEMENT OF THE PROBLEM

Residential treatment of emotionally disturbed adolescents continues to evolve from what once was rather basic medical or institutional care for ill or abandoned children or dissocial youth to an increasingly sophisticated treatment modality (Brendtro, 1990; Margolis, McDermott, & Vaughan, 1984; Zimmerman, 1990). While difficulties with troubled youth are not new, public attitudes about how to deal with them have varied over the years (Jones & VanderVen, 1990; Traber, 1990). Economic considerations have undoubtedly played a part in such changing attitudes, but emotional ambivalence towards the care and nurture of children and adolescents also appears to be a factor (Miller, 1983).

My interest in this area was stimulated through my work in a residential treatment centre (RTC) for emotionally disturbed adolescents that appeared to have achieved some excellent long-term outcome results (Blackman, Eustace, & Chowdhury, in press). However, the precise explanation of how these results occurred proved difficult, thereby giving rise to a number of questions. Was the treatment itself effective, or could the centre's success have been due to the adolescents' own maturation or the removal from an overly-stressful environment? Could it have been the charisma of the program psychiatrist, or the structure of the program or any other of a number of possibilities? If there were therapeutic processes operating in the RTC, what were the central or essential ones? What were the key treatment ingredients?

Examination of the professional literature, as shown by Chapter two, indicated that more research was needed to answer these questions. It appeared that the treatment process in particular, so central to the whole enterprise, was not very well understood or extensively researched. The literature also revealed that one source of information was often left untapped, namely the consumers of treatment – especially the adolescents themselves. Finally, the literature indicated a number of methodological problems challenging potential researchers in this area.

Assessment of these problems led to the consideration of alternative research methodologies. One method, the grounded theory method (presented in chapter 3), seemed particularly promising because of its orientation towards discovery rather than verification. Researchers (Hutchinson, 1988; Stern, 1980) spoke of how this method could be especially helpful when one wants to either identify salient variables in relatively new areas or obtain a fresh perspective to help address practical problems in familiar areas. As residential treatment has elements of both the old and the new, this method seemed to offer some advantages. The grounded theory method also anticipates that initial research questions may evolve and be transformed as the study proceeds (Strauss & Corbin, 1990). Due to the uncertainty regarding the precise definition of the central or crucial processes operating in the RTC, this method again seemed potentially useful.

Therefore, based on the first review of the literature and the decision to employ an alternative methodology, it was initially decided that the aim of the study would be to utilize the perceptions of adolescents who had undergone treatment at the RTC mentioned earlier to generate a data-based theory about effective residential treatment. The theory would first answer two questions: (a) what are the basic psychosocial processes occurring while adolescents are in residential treatment that are related to successful long-term outcome?, and (b) what are the key treatment ingredients that are involved in operationalizing these processes? Secondly, the theory would be relevant in a practical way for those working with adolescents. To help achieve these goals, it was decided that adolescents who appeared to have benefitted from being in the program, as adjudged by their satisfactory post-treatment adjustment, would be the primary sources of information.

The findings of this study are presented in chapters 4 and 5. Using grounded theory methodology, two central processes, called basic social psychological processes (BSPPs) were discovered. These two processes, respectively labelled **Doing Your Work** and **Being Helped**, were perceived by the adolescents as being of particular importance in the therapeutic enterprise. In chapter 4, after an introduction to the themes of "work" and "help," the BSPP of Doing Your Work is examined in more detail and a substantive theory about working (in a psychosocial sense) is presented. A similar procedure is followed in chapter 5 when the BSPP of Being Helped is discussed and a substantive theory about being helped is presented. In chapter 6 the findings of this inquiry are placed within the context of other research. Similarities and differences between concepts in this study and similar concepts in other studies are noted and discussed. Following this discussion, a more formal substantive theory of working and being helped - which incorporates and consolidates findings in the literature with those of this study - is developed and presented. This theory is presented in a sufficiently abstract form that it begins to approach the level of formal theory (Glaser, 1978). However, it is hoped that it is also presented in a sufficiently practical manner that it can be used by helping practitioners in any setting, and particularly by those in an adolescent residential setting. Lastly, in chapter 7, after the study is briefly summarized and its findings evaluated, the strengths and limitations of this study are examined. Following this, some of the implications for future research and practice are discussed before the chapter is closed with some concluding comments and a quotation from one of the adolescents.

CHAPTER TWO

LITERATURE REVIEW

Introduction

There is some debate in the literature of grounded theory about the role of the literature review. Because of the emergent nature of the data, and the fear of preconceived notions "biasing" perceptions of this incoming information, some authors suggest delaying the literature review entirely until the initial fieldwork is done (Glaser, 1978; Hutchinson, 1988; Rennie, Phillips, & Quartaro, 1988). Others suggest doing only a moderate review at first in order to acknowledge one's present knowledge (Strauss & Corbin, 1990) and to provide the rationale for launching the study (May, 1986), leaving open the option of a later review. Still others suggest a relatively detailed literature review initially, to be followed by additional forays into the literature as emerging data further inform the researcher (Chenitz, 1986a; Sandelowski, Davis, & Harris, 1989).

The present study subscribes more to the last approach. To this writer it seems most congruent with the spirit of grounded theory methodology – i.e., it implies that there can be no such thing as a truly objective or unbiased observer even if one imagines that by being uninformed one can remain naive (Giorgi, 1970; Pearce, 1971), yet it also allows the researcher to maintain a dialogue between the data in the field and the data in the literature as the phenomena under study emerge (Chenitz, 1986a). Therefore this initial review will first provide a background overview and orientation to the preliminary research questions and then will demonstrate the need for further research into the treatment processes in an adolescent RTC.

What is Residential Treatment?

During the first decades of this century, adolescents with mental health problems were not seen as a unique group in need of specialized mental health services (Fineberg, Sowards, & Kettlewell, 1980; Zimmerman & Sanders, 1988). By the early 1940s this began to change (Fineberg et al., 1980). Gradually a spectrum of services became available to adolescents, ranging from individual therapy through family and group therapy to foster and group home care to residential placement or hospitalization (Feist, Slowiak, & Colligan, 1985; Mishe, 1984; Wilson & Lyman, 1983). Of these services, residential treatment continues to be one of the more controversial approaches (Adilman, 1973; Collins, 1988; Kennedy, 1985; Zimmerman, 1990).

The rather bland phrase "residential treatment of emotionally-disturbed adolescents" masks its turbulent, controversial evolution. Some of this controversy stems from disagreement about what fundamentally constitutes residential treatment.

Although many writers today would still agree with Hylton (1964) that residential treatment is a total therapeutic program for children [or adolescents] whose emotional problems prevent outpatient treatment in the community, others would also agree with Maluccio and Marlow (1973) that the term "covers such a wide constellation of children, goals, and programs that it is vague and of questionable utility" (p. 232).

It appears that the problem of definition has yet to be resolved. Johnson (1982) states that there is no accepted definition of residential treatment and settles for providing general characteristics. Kennedy (1985) notes that it is often erroneously assumed that residential treatment is an "entity which is specific and universal in philosophy" (p. 18). He states:

> The term has become so general it is meaningless and can span the spectrum from unsophisticated "treatment orientated" settings, which are many, to high quality, academic, university-affiliated in-patient units which are few (p. 18).

To further complicate matters, the terms residential care and residential placement - terms which may or may not involve treatment - are often used interchangeably with the term residential treatment (Barker, 1988; Durkin & Durkin, 1975; Roush, 1984; Whittaker, 1979).

Although some writers seem to prefer to distinguish between hospital inpatient treatment and residential treatment (Fineberg, Sowards, & Kettlewell, 1980; Zimmerman, 1990), others prefer to think of residential treatment as treatment that occurs in either a residential centre or an inpatient hospital setting (Kennedy, 1985; Rinsley, 1980). This latter view is the one that will be followed in this paper.

Difficulty in defining residential treatment has created other problems. Kennedy (1985) notes that lack of clarity in definition has resulted in a situation where "accurate reliable evaluation is impossible and distorted conclusions reflecting vested interests and biases are inevitable" (p. 18).

Why is there no consensus on definition to date? In part this is due to the diverse historical roots of modern residential treatment.

Historical Development of Residential Treatment

Modern residential treatment for emotionally disturbed adolescents is the result of a confluence of two major historical trends - residential care for children and inpatient treatment for adults (Brendtro, 1990; Zimmerman, 1990). Their accompanying themes, "raising" and "treating," are still central issues in residential treatment (Barker, 1982; Durkin & Durkin, 1975; McElroy, 1988).

Residential care evolved from the basic custodial care originally provided to abandoned or neglected children in orphanage-type institutions (Johnson, 1982). As difficulties were encountered in caring for these children, their care-givers increasingly turned to outside professionals for assistance. Education and psychotherapy began to replace custodial care. Eventually these professionals were grafted onto the residential care system (Margolis, et al., 1984).

In contrast, inpatient treatment for adolescents developed as psychiatrists decided that outpatient treatment for younger patients, as had earlier been decided for adult patients, often needed to be supplemented environmentally (Barker, 1982, Margolis et al., 1984). This was particularly true for special populations such as suicidal or psychotic adolescents (Barker, 1988). Consequently, attempts were made to develop benign or at least neutral environments to counteract previous pathogenic environments – particularly negative family environments – that might block or hinder individual therapeutic progress (Bettelheim, 1974). In this case the residence was secondary to the treatment process. These two systems – environmental management and psychotherapy – began to fuse as psychoanalysts and psychiatrists became directors of residential centres just before and after World War II (Margolis et al., 1984).

The Therapeutic Milieu

The pioneering efforts of Aichorn (1935), Bettelheim (1950), and Redl (1952, 1959a) led to the development and elaboration of the analytically-based concept of the "therapeutic milieu." Although somewhat vague, this phrase referred to "the application of psychoanalytic concepts to the specific task of creating a therapeutic environment for emotionally disturbed children who are in need of residential treatment" (Bettelheim & Sylvester, 1949, p. 54). In such a setting, daily events and activities are systematically planned and used as therapeutic tools (Aichorn, 1935).

Bettelheim and Sylvester (1948) see the milieu as characterized by an inner cohesiveness which enables a child to develop a consistent frame of reference. This cohesiveness is experientially absorbed by the child as he or she participates in continuous, meaningful relationships and "finds" his or her place. In a therapeutic milieu all of the factors which make up the environment, e.g., schedules, meetings, and routines are subordinated to the development and maintenance of the interpersonal relationship. To encourage this, spontaneity and flexibility (not to be misconstrued as license or chaos) are stressed more than dogmatic rules or rigid schedules. Doing this facilitates the creation of "a home that smiles, props which invite, space which allows" (Redl & Wineman, 1957, p. 6).

The Therapeutic Community

Parallel work in England by Main (Main, 1946) and Jones (1952, 1956) in developing the concept of "therapeutic community" for emotionally disturbed adults began to influence those working in hospital settings. As envisioned by Jones (1956), a therapeutic community of adults should stress the importance of broadly-based leadership, decision-making by consensus, and the furtherance of "social learning."

To achieve this, Jones (1968) says the hospital ward must be re-structured to: (1) allow two-way communication between and among both patients and staff, (2) encourage participation in decision-making at all levels, so that everyone has the feeling that he or she is identified with the aims of the hospital and its success and failures as it evolves and changes, and (3) develop a therapeutic culture which reflects the attitudes and beliefs of patients and staff and stresses the importance of relationships.

As the concepts of the therapeutic milieu and the therapeutic community became more influential, a number of previously individually-oriented RTC's began to incorporate them into their settings. The particular orientation of each director determined which notion - individual therapy, therapeutic milieu, or therapeutic community - was most emphasized.

Over the years, the terms therapeutic community, therapeutic milieu, and milieu therapy have often been used interchangeably (Devine, 1981; Gunderson, Will & Mosher, 1983; Hersov & Bentovim, 1985). However, there are indications that the term therapeutic community is now being used less often in hospital settings (Stauble, 1988), but more often within the context of adolescent drug rehabilitation programs (Biase, 1984; Deitch & Zweben, 1976; Kajdan & Senay, 1976; Rosenthal, 1989).

The term therapeutic milieu has branched out from its original roots and is now often found in descriptions of inpatient hospital wards (Devine, 1981; Fineberg et al., 1980; Zimmerman & Sanders, 1988). It also appears that most residential treatment programs (except perhaps for pharmacologically-based hospital programs) see the therapeutic milieu as the cornerstone of their treatment program (Fineberg et al., 1980; Gossett, Lewis & Barnhardt, 1983; Roush, 1984).

Adolescent Services

After the idea of the therapeutic milieu began to take hold in the 1950s, the notion of specialized services for adolescents increasingly began to be championed in the late 1950s and early 1960s (Garber & Polsky, 1970). Prior to this time, adolescents were usually viewed as either "older children" or "younger adults", and were offered services based on either child or adult models of treatment (Tramontana, 1980; Zimmerman & Sanders, 1988). Although one can still find writers who seem to view adolescents in one of these ways (Barker, 1988; Wilson & Lyman, 1983), it is now generally conceded that adolescents are best considered a unique group entitled to their own specialized services (Gossett, et al., 1983; Zimmerman & Sanders, 1988; Zimmerman, 1990).

Characteristics of Residential Treatment Centers

As health care costs soared during the late 1960s and 1970s, calls for accountability in the areas of cost-effectiveness and quality-care standards increased. This led to a brief reduction in the demand for residential treatment as other approaches were tried and as funding for centers which did not meet approved standards was stopped (LeCroy, 1984; Margolis et al., 1984; Whittaker, 1975). One effect of these actions was renewed attempts to more accurately describe what residential treatment was (Margolis et al., 1984). Again no consensus about an operational definition emerged; however certain characteristics did seem to gain general acceptance. Adler's (1968) key concepts are often cited (Johnson, 1982; Maluccio & Marlow 1973). He sees residential treatment involving:

1. Planned, ordered living;

2. Authority, with opportunities for children to work out their feelings about it;

3. Emphasis on health rather than pathology of the personality;

4. Group living designed to promote socialization and growth opportunities;

5. Positive identification through opportunities for significant relationships, enabling the formation of esthetic and ethical values;

6. Child-staff interaction;

7. Community - the sense of being an integral part of one;

8. Integration - the joint planning and evaluation of the child's treatment plan by all staff.

After surveying other writers Maluccio and Marlow (1973) list additional characteristics:

1. Treatment based on diagnosis;

2. Therapeutic goals which include education;

3. Interaction and coordination between environment and psychotherapy;

4. Effective utilization of the therapeutic potentials of each staff member;

5. Provision of staff training programs;

6. Involvement of parents in the treatment process.

Whittaker (1979), perhaps thinking somewhat ideally, cites further characteristics:

1. Low visibility - small centers that fit harmoniously into their community;

2. Larger community interaction - programs that are actively involved with the communities that support them;

3. Flexibility - to quickly shift gears in response to changing service demands;

4. Programs described in plain, simple language which can be understood by the lay public.

Margolis et al. (1984), reporting on the development of standards for residential treatment centers funded by CHAMPUS (Civilian Health and Medical Program of the Uniformed Services), state that a basic standard for quality of care is an acceptable level of "medical presence." This is defined as "psychiatric evaluation, ongoing assessment, physician participation in treatment, neurological consultation and pediatric care" (p. 483).

Despite this ever-growing list of characteristics, there is still no definitive definition of residential treatment for emotionally disturbed adolescents (Kennedy, 1985). The term continues to elude precise definition even though most people seem to have a reasonable idea of what is being discussed. Perhaps the best that can be achieved at this time, in keeping with Kennedy's observations, is for each writer to describe the particular residential treatment program he or she is discussing.

Organizational Models of Residential Treatment

Today, most residential treatment centers follow one of two major organizational models: the residential care center model or the hospital inpatient ward model. In the residential care model the child care staff, who have become increasingly professionalized over the years (Johnson, 1982; Maier, 1987; Small & Alwon, 1988), are the primary therapists and custodians (Roush, 1984; Whittaker, 1979). Other professionals may be used on an adjunct basis for specific tasks, e.g., family therapy, but the critical work is seen as happening in the therapeutic milieu during the "other 23 hours" (Trieschman, Whittaker, & Brendtro, 1969; Whittaker, 1979).

In the hospital inpatient model, roles tend to be more specialized (Crabtree & Levinson, 1980). In some wards these roles are co-ordinated to present a unified "team approach" (Davis & Raffe, 1985), while in others the various professionals operate more or less independently as the nurses assume the role of the primary care provider within the context of the therapeutic milieu (Amini, Burke, & Edgerton, 1978).

In both models, the ratio of staff to clients is quite high, but this is often presented in a misleading way – i.e., it is not always clearly demonstrated that three shifts of staff are necessary to provide one continuous "shift" to the clients or patients. Finally, although opinions about optimal group size vary (Hersov & Bentovim, 1985), most writers report that adolescent patients or clients are best managed in relatively small groups ranging from about 8 to 15 adolescents (Feist et al., 1985; Gossett et al., 1983; Schaefer, 1980).

Characteristics of Residential Clients

The adolescents for whom residential treatment is designed should be those who cannot otherwise be treated safely and successfully within a community-based setting, i.e., a family home, or a therapeutic group or foster home (Rinsley, 1980). Barker (1982) stresses that we should always scrutinize our real reasons for admitting children and adolescents to residential treatment centers.

Lately, adolescents admitted to RTCs are more likely to be described in terms of their presenting symptoms (e.g. aggressive impulse disorders, depressed or suicidal disorders, or psychotic disorders) or their behaviors (e.g. easily distractible, withdrawn) rather than by older, historical terms which have come to be seen as pejorative (e.g. neurotic or juvenile delinquent) (Johnson, 1982; Gossett et al., 1983; Hersov & Bentovim, 1985). Use of the relatively value-free behavior descriptions (e.g. Conduct Disorder, Eating Disorder) of the DSM (III) or DSM (III-R) (APA, 1980; APA, 1987) is common practice in hospital-based or associated settings (Blackman, et al., in press; Kennedy, 1985).

Whittaker (1979) dislikes such diagnostic labels as character disorder, schizophrenic, or psychotic. He prefers to use problem clusters, stated in everyday language, to describe the behavior of those adolescents suitable for residential treatments. He uses phrases such as: poorly developed impulse control, low self-image, poorly developed modulation of emotion, relationship deficits, family pain and strain, special learning disabilities, and limited play skills.

Rinsley (1980) states that the adolescent who requires admission is invariably found to be seriously disturbed. Psychodynamically oriented, he says that the vast majority of such patients suffer from a form and degree of psychopathology most correctly indicated by the terms "borderline" or "schizophrenic". According to Rinsley:

1. Most of these adolescents are suffering from a degree of anxiety conducive to pervasive disorganization of

the personality, regardless of their specific presenting symptoms.

2. These adolescents are unable to sustain significant relationships with others and hence have been unable to effectively communicate the extent of their subjective suffering.

3. These adolescents have usually signalled this suffering through various kinds of disordered action or overt behavior.

4. Thorough and careful protection, including external controls, is required to ease these adolescents' anxiety and promote meaningful communication with those attempting to help them.

5. Most adolescents with these kinds of problems are from families in which one or both parents suffer from serious mental disorder - and consequently are psychologically or physically unavailable to them.

Major Approaches to Residential Treatment

With the development of specialized services for adolescents and the addition of adjunct treatments such as group and family therapy, and occupational and recreational therapy, a diversity of residential treatment approaches began to emerge. In addition to the psychoanalytically-based theories of residential treatment discussed earlier, and later extensions of this approach (Masterson, 1972;

1982; Rinsley, 1980), other treatment approaches were advocated.

Behavioral and social-learning based models began to gain recognition in the 1960s (Phillips, 1968). At first they were used with such populations as juvenile delinquents where traditional approaches had failed (Stumphauzer, 1986). The Achievement Place project for young juvenile delinquents is probably the best known example of the behavioral training approach (Phillips, 1968; Phillips, Phillips, Fixsen, & Wolf, 1974). Elements of its program, such as its use of token economies, have served as models for other programs (LeCroy, 1984).

Other approaches that began to gain attention during the 1960s and early 1970s were based on social-systems theory and research. A classic study in this area was the study by Polsky (1962). His book, Cottage Six, demonstrated that many therapeutic inroads begun by an adolescent's psychiatric case-worker were often stymied by the adolescent's delinquent sub-culture.

Awareness of the influential power of these social systems led to the development of the "Positive Peer Culture" approach, whereby an adolescent's peers are enlisted in the process of helping him/her learn new pro-social behaviors (Schaefer, 1980; Vorrath & Brendtro 1974). Other approaches based on social systems principles have resulted in the "ecological perspective" (Lewis, 1982, 1986). This latter approach stresses the notion that the behavior setting strongly influences behavior that occurs within it. Development is seen as resulting from interactions between the growing adolescent and selected components of his or her personal ecology (Lewis, 1982).

Because the family is often seen as the critical social system for adolescents, some models of residential treatment are based on the analogy of a healthy family (Roberts, 1988; Looney, Blotcky, Carson, & Gossett, 1980). Other writers have seen the school as the critical social system and have designed their treatment models with an educational base. Project Re-Ed is one of the best-known examples of this latter approach (Hobbs, 1982; Lochman, Bennett, & Simmers, 1988).

In addition to these major approaches, such variations as the therapeutic community drug rehabilitation programs referred to earlier or idiosyncratic models like Reality Therapy (Glasser, 1965) have been influential in residential work with adolescents (Bassin, Bratter, & Rachin, 1976). Another model which shows promise for influencing adolescent treatment is the biopsychosocial model (Engel, 1980). This model is based on an understanding of General System Theory (von Bertalanffy, L., 1968, 1974; Weiss, P., 1969). Within this framework, the biological, psychological, and sociological factors underlying psychopathology, and normal development can be usefully integrated (Blackman et al., in press; Doherty, 1991).

Present-day Status of Residential Treatment

During the 1980s there has been a persistent demand for residential services (Fineberg, Kettlewell, & Sowards, 1982; Johnson, 1982; Zimmerman & Sanders, 1988). Although some writers view residential treatment as generally unnecessary (Haley, 1980), most now believe that properly used, residential treatment is a viable and often necessary choice (Barker, 1982; Cates, 1986; Schaefer & Swanson, 1988). It is often emphasized that residential treatment should not be an entity in itself, but rather a link in a total treatment process which includes pre-residential and post-residential care (Blackman et al., in press; Whittaker, 1979).

Yet despite the demand for residential treatment, much controversy still surrounds it (Kennedy, 1985). Why is this? Some of the major reasons, as indicated by the inability of writers to agree on a universal definition, are that there is no consensus on: (a) the specific form residential treatment should take, (b) whom it best serves, or (c) what the essential ingredients of effective treatment are (Fineberg et al., 1980; Gossett et al., 1983; Kennedy, 1985). This lack of agreement suggests the field is still growing and evolving.

Another major reason is that outcome research has not, to date, conclusively demonstrated the effectiveness of adolescent residential treatment in either the short or the long-term. Although there is accumulating evidence about the efficacy of residential treatment (Blackman et al., in press; Fineberg et al., 1980; Gossett et al., 1983; Lochman et al., 1988), it is not conclusive (Collins, 1988; Kennedy, 1985; Pfeiffer, 1989). Outcome studies are particularly important not only because they address the question of general effectiveness, but because they are also used to help either validate the effectiveness of particular treatment interventions or delineate active treatment ingredients (Pfeiffer, 1989).

Another reason for the ongoing controversy is the difficulty in comparing research studies. This can be due to either conceptual and methodological differences in approach or, unfortunately, to conceptual and methodological flaws in conducting research. Complaints about the quality of studies, particularly outcome studies, have been unceasing (Durkin & Durkin, 1975; Johnson, 1982; Lewis et al., 1980; Pfeiffer, 1989; Zimmerman & Sanders, 1988). Lewis, Lewis, Shanok, Klatskin, and Osborne (1980), after reviewing several studies, state:

> The lack of uniform criteria for adequate adjustment, the variety of methodologies for assessing follow-up

> status, and the difficulties establishing the nature of residential treatment interventions make the outcome studies to date of limited value in terms of designing effective programs. . . . (p. 162)

Pfeiffer (1989) in a methodology review of 32 outcome studies of child and adolescent inpatient psychiatric treatment notes that "Although the majority of published follow-up investigations report positive outcomes. . . the associated conceptual and methodological flaws make firm interpretations of findings inconclusive" (p. 15). Therefore, it would appear further research is needed both to determine the general effectiveness of residential treatment and to identify the essential therapeutic processes and treatment ingredients involved in the instigation and maintenance of short and long-term change.

Because of the difficulties in comparing research results, researchers have often settled for summarizing the findings around particular issues. Zimmerman and Sanders (1988) suggest that the major research concerns today can be grouped under four major headings: (a) issues relating to demographics and patient description, (b) issues involving diagnosis, (c) treatment issues; and (d) issues involving outcome evaluation. Although this study is concerned with the third category, treatment issues, because the effectiveness of treatment interventions is often determined by outcome studies, there is a natural overlap among these two groups of studies.

Treatment Issues

One of the weakest areas of research in the field of adolescent residential treatment has been the delineation of the critical treatment variables and processes (Fineberg et al., 1980; Pfeiffer, 1989; Zimmerman & Sanders, 1988). Although researchers and theorists have advocated systematic assessment of the treatment milieu in order to determine the key ingredients and conditions functioning within the milieu for many years (Feist et al., 1985; Johnson, 1981; Moos, 1974a), most research to date has tended to focus upon the evaluation of treatment success rates, instead of the actual description of the treatment process (Zimmerman & Sanders, 1988). One is left to wonder: (a) exactly what are the key treatment ingredients that must be present to catalyze change?; (b) can they work independently?; or (c) must there be some kind of "gestalt process" that requires a certain number of ingredients to be present in sufficient proportions to be effective?

As noted earlier, research into the actual treatment processes has been hampered by conceptual and methodological difficulties. Different treatment philosophies inevitably lead to different treatment approaches. Program comparisons become complicated by their many dissimilarities.

Fineberg et al. (1980) list a number of the difficulties encountered in doing traditional outcome research in adolescent inpatient programs. These difficulties would also seem to apply to research into the treatment process. Some of these difficulties arise from:

(1) Different settings: e.g., all adolescent wards vs. mixed wards; with or without special adolescent programs; hospital vs. residential center.

(2) Different programs: e.g., psychoanalytically-oriented programs vs. token-economy programs vs. systems-based programs.

(3) Different client populations: e.g., variations in the proportion of males and females, and in the distributions among categories of age, socioeconomic status, race, religion, and diagnosis.

(4) Different selection policies: e.g., randomized vs. criteria-based, or simple waiting-list, or combinations thereof.

(5) Different lengths of stay: crisis vs. brief vs. medium or long-stay.

(6) Different research designs: with or without control groups; with or without replications.

(7) Different dependent variables: Some authors use only one or two general variables; others use a number of more specific variables.

(8) Different procedures: e.g., time of interview after discharge; interview procedures: face-to-face vs. telephone vs. letter; interviewers: previously known vs. neutral.

(9) Different methods of analysis: e.g., anecdotal vs. descriptive percentages vs. sophisticated statistical analyses.

Given the number of ways in which programs and the ways they could be researched might differ, it should not be too surprising that research efforts to specify more precisely the key treatment ingredients and their appropriate blends have usually yielded only general factors or descriptions (Zimmerman & Sanders, 1988).

The lack of clear identification of the essential therapeutic ingredients appears to be the reason most RTC's use the "shotgun" approach. Although debate continues, most RTC's consider the following elements crucial to effective treatment:

1. The therapeutic milieu is the "foundation," "cornerstone," or "backdrop" for all the other therapies. It is the primary and most powerful form of intervention (Fineberg et al., 1980; Gossett et al., 1983; Johnson, 1982; Roush, 1984).

2. The development and maintenance of a structured, therapeutic environment with rules, routines, expectations, sanctions, and incentives – organized and implemented in a clear, consistent way – is crucial to program success (Fineberg et al., 1980; Rinsley, 1980; Roush, 1984).

3. A high staff-to-client ratio and a high level of staff communication and team work, with effective procedures for resolving conflicts and tensions, is critical (Feist et al., 1985; Johnson, 1981; Roush, 1984).

4. The therapeutic power of both staff and adolescent groups must be harnessed and brought to bear on the problems of the individual adolescent (Beitel, Everts, Boile, Nagel, Bragdon & MacKesson, 1983; Gunderson, 1978; Schaefer, 1980).

5. Child care staff play a critical role. They can provide social reinforcement of appropriate behavior, faster, effective, supportive and problem-solving modes of communication, and healthy role models for identification-imitation learning (Feist et al., 1985; LeCroy, 1984; Whittaker, 1979).

6. Educational and recreational activities can provide age-appropriate opportunities for adolescents to develop competency in basic life skills (Johnson, 1982; LeCroy, 1984).

7. Except for centers using pure behavioral modification strategies, most centers employ a variety of traditional therapeutic modalities including individual, group and family therapy (Blackman et al., in press; Kennedy, 1985; Zimmerman & Sanders, 1988).

Outside of these "core" treatment elements, most of which still leave room for interpretation and debate, there are a number of other contentious treatment issues. Much of the research on these latter issues is tied into short or long-term outcome studies, because such studies provide feedback about the "goodness of fit" between the client and the program (Gossett et al., 1983). These issues will be discussed under three overlapping headings: milieu concerns, therapy concerns, and research concerns.

Milieu Concerns

As noted earlier, it has been recognized for many years that the therapeutic milieu or treatment environment has a critical impact on both the patient and staff (Bettelheim & Sylvester, 1948; Feist et al., 1985; Moos, 1974a). Some writers go even further. Those who take an ecological or comprehensive systems approach believe that the whole environment of the adolescent should be considered, not just the therapeutic milieu. They believe representatives of all the significant social systems within the adolescent's ecology should be involved, i.e., parents, teachers, juvenile courts, insurance companies, social welfare agencies, and health-care professionals (Lewis, 1982; Madow, 1988; Termini, 1991; Whittaker, 1975).

Although looking at the broader social context approach has its advocates (Lewis, 1988), the main focus continues to be on the milieu itself. Examination of therapeutic milieu studies suggests they have either been devoted to the examination of a single issue hypothesized to make a critical impact upon the development of the therapeutic milieu or have been of a more theoretical or descriptive nature, reflecting concern about a number of issues.

Examples of single-issue concerns would be whether adolescents should be treated in open or closed settings (Rinsley, 1980); whether there should be mixed wards (e.g. adolescent and adult patients) or all-adolescent wards (Gossett et al., 1983; Rinsley, 1980; Zimmerman & Sanders, 1988); or whether the "time-out" procedure can be used to discourage acting-out behavior (Crespi, 1988).

Examples of more inclusive, descriptive articles would be those by Rose (1986, 1987a, 1987b, 1988a, 1988b) who makes persuasive use of literary and clinical anecdotes to stress the necessity of designing a therapeutic atmosphere. Rose draws on his many years as Director of Peper Harow, a RTC for "profoundly disturbed adolescents", to simultaneously discuss a number of issues and ingredients to be considered in creating an "enchanting" therapeutic milieu - such as the roles of architectural design, food, storytelling, and learning activities.

However, it appears that to date relatively little empirical research has been done to identify precisely those milieu variables which affect adolescent patient symptoms, satisfaction, and improvement (Pfeiffer, 1989). Some of the few studies done in this area were stimulated by the research Moos and his colleagues (Moos, 1974a; Moos & Houts, 1968; Moos & Schwartz, 1972) did on adult inpatient wards.

In an attempt to determine which milieu characteristics contributed to optimal treatment outcome, Moos and his colleagues conducted an extensive series of studies to characterize the treatment environment. In 1968, Moos and Houts introduced the Ward Atmosphere Scale (WAS), which was based on Murray's (1938) concept of environmental press. Murray had suggested that individuals have specific needs which the environment potentially satisfies or frustrates, and that behavior is the result of the interaction between personality needs and environmental press. While most researchers after Murray focused on personality variables, Moos attempted to objectively measure those environmental variables that influence the individual. His Ward Atmosphere Scale identified three basic dimensions that characterize different kinds of environments, namely:

Relationship dimensions, Treatment Program or Personal Development dimensions, and Administrative Structure or System Maintenance dimensions.

Relationship dimensions examine the involvement of individuals in the environment, and the extent to which they support and help one another. The Treatment Program or Personal Development dimensions assess the basic directions along which personal growth and self-enhancement tend to occur in a particular environment. The Administrative Structure or System Maintenance dimensions assess how organized a program is, and how orderly, clearly, and coherently it is functioning.

The WAS has become a relatively popular instrument for assessing milieu functioning or initiating organizational change (Johnson, 1981; Feist et al., 1985).

Roush (1984) extended the work of Moos (1975) to develop an operational definition of the therapeutic milieu. He states that "as a function of program and staff development [the therapeutic milieu] represents a systematic strategy for the creation of an institutional social climate which fulfills the personal needs of residents" (p. 276). It would appear from this definition that Roush believes that a therapeutic milieu does not "just happen." It must be created. Indeed, he goes on to say that there must be an active approach towards program development, because program development is the key medium for creating a therapeutic milieu.

In Roush's opinion, the two primary factors which can be beneficially manipulated through program development are (a) the social climate of the environment and (b) the approach to discipline. By "discipline" he means those strategies for resolving conflict associated with the identification and remediation of misbehavior. Roush says "the quality of an institutional program is reflected by its approach to discipline" (Roush, 1984, p. 243).

Therapeutic Concerns

It is beyond the scope of this review to discuss the numerous variations of psychotherapeutic intervention that have been attempted over the years. The basic models and approaches were mentioned earlier. Instead, a survey of some of the salient concerns found throughout all the different theoretical approaches will be presented. Again much of the work in this area is anecdotal or descriptive.

There has been an ongoing concern about identifying essential therapeutic processes and treatment ingredients (Pfeiffer, 1989; Zimmerman, 1990). Some authors have drawn on clinical experience in an attempt to specify these ingredients or processes. Gunderson (1978) conceptually attempted to move beyond the impact of descriptive variables (e.g., staff attitudes) on the therapeutic milieu to the identification of the major therapeutic processes which commonly exist in a broad range of therapeutic milieus. He referred to these processes as "functional variables," because they "reflect operations or processes provided by the staff which are recognizable largely by their effects on the patients" (p. 327). Gunderson conceptualized five major therapeutic processes or functional variables and attempted to operationally define them. The five variables were: containment, structure, support, involvement, and validation. He hoped that the identification of these functions could help provide guidelines (not recipes) for those who would like to structure or select a milieu program to accommodate particular patient needs, treatment goals, or institutional requirements.

The power of the adolescent's peer group and the absolute necessity for enlisting it as a therapeutic force was referred to earlier (Schaefer, 1980; Vorrath & Brendtro, 1974). There is ongoing concern about how best to help the adolescent and his or her peer group develop prosocial values when the peer group is composed of individuals who "suffer from significant social skills deficits, overaggressive and antisocial behaviors, fears of groups, distortions in reality assessment, hyperactivity, impulsiveness, and other ego weaknesses" (Gwynn, Meyer, & Schaefer, 1988, p. 104).

Powerful though the adolescent group may be, in an effective setting the adult group should ultimately be more influential (Rose, 1986). The crucial variable here is usually referred to as staff cohesion, although Bettelheim (1974) refers to it as social solidarity.

Johnson (1981) sees staff cohesion as the most crucial treatment process variable and a factor which profoundly influences other variables in the treatment environment. In her study using one of Moos's instruments (Moos, 1974b), she found that low staff cohesion significantly affected a number of specific variables pertaining to the quality of the treatment environment. It decreased the amount of Support, Personal Problem Orientation, Practical Orientation, and Autonomy (subscales of the instrument) in the treatment environment and increased the amount of Staff Control. Staff cohesion is also seen as a key variable in creating a milieu that effectively minimizes or contains the "outbursts" of disturbed adolescents who act out physically (Davis & Raffe, 1985).

Because of rapidly escalating health-care costs during the 1970s and 1980s, there has been continuous concern about how more cost-effective treatments can be developed (Margolis et al., 1984; Wilson & Lyman, 1983). Concerns have also been expressed about the effects of long-term hospitalization on the client (Bloom & Hopewell, 1982), particularly the emotional effects of long-term separation from his or her family or community (Fineberg et al., 1982; Shafii, McCue, Ice, & Schwab, 1979). Although there has been a trend towards developing briefer therapies for adolescents in residential care for some years now (Kennedy, 1985), there has also been controversy over the optimal length of residential stay (Fineberg et al., 1980; Lewis et al., 1980). Determination of the time needed for successful treatment of specific adolescent disorders is ongoing, and likely to provoke controversy for some years to come (Madow, 1988).

Although the concern over "continuity of care" (i.e., the need for both pre- and post-treatment resources) was seen as a developing idea in the late 1970s (Whittaker, 1979), in this writer's opinion there are few institutions today that do not at least pay lip-service to this concept. Problems of "transition" have been noted and discussed (Fruedenberger & Carbone, 1984; Shachter, 1978). However, institutions which have actually been able to operationalize and implement the concept of continuity of care appear to be relatively rare (Blackman et al., in press; Kennedy, 1985).

In keeping with the notion of continuity of care is the trend toward greater parent and family involvement. Originally, treatment programs were often designed to keep parents from contaminating the treatment process

(Bettelheim, 1974). However, programs are becoming increasingly flexible about parental involvement. Discussions are now about the best way to involve the family in treatment (LeCroy, 1984; Tracy, 1988; Van Hagen, 1988; Walsh, 1985).

Somewhat surprisingly, there appears to be relatively little concern for the opinions of those most affected by a treatment program - namely the immediate consumers of treatment, i.e., the adolescents and their families. Although obtaining consumers' opinions about their treatment in order to improve program effectiveness has been periodically advocated, there seem to be relatively few studies reporting in-depth inquiries of consumers. In one of the early studies which reported consumer's views, Garber and Polsky (1970) stated that the reactions of former patients to their hospitalization were "valuable points that should be noted and considered by therapists and administrators alike" (p. 187).

A later study by Fineberg et al. (1982) noted that there were very few outcome studies that had sought consumer feedback. These researchers found consumer feedback about their treatment program to be quite positive and very helpful for maintaining program effectiveness. In one of the few other studies which used consumer feedback, Leone et al. (1986) found that although both successful and unsuccessful students generally viewed their treatment program positively, the successful students tended to dissociate themselves from enrollment in the program. Successful students indicated that they would not tell prospective employers that they had been enrolled in a specialized treatment program. Instead they would tell employers that it was a regular high school program. It is hoped that future research will consider more involvement with consumers as they appear to be an under-used resource in determining treatment effectiveness.

Research Concerns

As these preceding studies indicate, research into the treatment process has been rather sparse and haphazard. Gossett et al. (1983) acknowledges that the treatment process and its relationship to outcome is an area of maximum interest to clinicians. However, they think that this area presents great difficulties for researchers because the methodological problems involved in distinguishing the specific influence of the numerous parts of a complex, diversified program are staggering.

Pfeiffer (1989) states that one of the more obvious conceptual shortcomings of research that has attempted to understand the efficiency of residential treatment is the limited attention given to delineating active treatment ingredients. In a review of 32 outcome studies of residential treatment, he notes that one third of the studies do not even mention the type or frequency of psychotherapeutic intervention. His review of these studies left him "with the distressing thought that, even if positive results are reported, there is little assurance that [residential treatment] was the causal factor" (p. 17).

Traditional research approaches have also been criticized for not yielding information useful to front-line workers. Durkin and Durkin (1975) illustrate this point by quoting a conversation reported in Goldenberg's (1971) study:

> **Scotty:** I think I know what's bugging you, Butch, but you know as well as I do that whether or not we get re-funded depends a helluva lot on what these statistics show after a year.
>
> **Butch:** Look Scotty, you don't have to remind me about that. I know all about it. Washington wants statistics: CPI wants statistics; the whole world wants statistics. I know all that shit and I know its important. All I'm saying is that, whether or not we're re-funded, if the research doesn't tell it like it really is – you know, what it feels like to work in a place like this, what its like to pour your whole self into a kid – then from my point of view it isn't worth a shit.

Comments like this illustrate the feelings and beliefs of many front-like workers that no matter how good the research is, it doesn't accurately capture the essence of "what is really happening." As a result, such research is often seen as "impracticable" by these workers.

While this writer believes that the traditional research methods will continue to be helpful in more precisely delineating the critical therapeutic processes and key treatment ingredients, it may also be the time to consider additional methods.

Mahrer (1988) argues that we must move beyond the traditional psychotherapy research methods that are oriented toward the testing of hypotheses to psychotherapy research methods that are discovery-oriented in order to really learn the secrets of psychotherapy. He states that the basis for designing discovery-oriented studies is the "intention to learn more; to be surprised; to find out what one does not already expect, predict or hypothesize. . ." (p. 697).

Rennie, Phillips, and Quartaro (1988) also believe that present approaches emphasize theory verification to the detriment of thinking and discovery. Although they are addressing the general field of psychotherapy research, their thoughts seem applicable to the field of residential treatment as well. Like Mahrer (1988), they have also called for alternative research approaches. They have suggested the use of the grounded theory approach (Glaser & Strauss, 1967) to help address this "crisis of method in psychology" (Rennie et al., p. 139).

Following these suggestions, the present study adhered to the guidelines for selecting subjects and collecting, analyzing, and presenting the data associated with the grounded theory approach (Glaser, 1978; Glaser & Strauss, 1967). The next chapter examines grounded theory methodology in more detail. Following an overview of this method, a description of how this study was conducted is presented. Lastly, a discussion of how the ethical issues in this inquiry were addressed is presented.

CHAPTER THREE

METHODOLOGY

Introduction

Grounded theory is a term used to describe both a method of doing research and the product of this method (Lorencz, 1988). It is a variant of the kind of research often referred to as qualitative research (Hutchinson, 1988; Strauss & Corbin, 1990). Many of the techniques used to gather data for this type of inquiry are associated with the approach known as naturalistic inquiry (Lincoln & Guba, 1985). As a methodology, grounded theory was specifically intended by its developers, Glaser and Strauss (1967), to be a method for generating useful, data-based theories, or as grounded theorists would say - theories "grounded" in the data (Corbin, 1986a; Glaser, 1978). As such, it differs from more traditional research approaches in that it does not presuppose any particular constructs or hypotheses (Glaser, 1978; Stern, 1980). Instead, it guides the researcher as she or he interacts in a recursive way with the emerging phenomenon being studied in order to produce a rigorous theory that fits the data, makes sense or works, is relevant to both participants and researchers, and can accommodate (is modifiable) to new information (Glaser, 1978).

Theoretical Context

Grounded theory fits into a mode of inquiry described as the "discovery mode" by Artinian (1988). This mode is second on a continuum of modes of inquiry ranging from the descriptive mode to the intervention mode. The first mode, the descriptive mode, precedes the others and is used to present a detailed description (descriptive narrative) of what is happening either in some setting or with a particular group of subjects. The discovery mode follows next. Although it may build on the first mode, its purpose is to generate theory, to conceptualize an underlying psychosocial process at an abstract level.

As a discovery mode or theory-generating methodology, grounded theory can be used to add to our knowledge either in areas that are already reasonably well-researched or in areas that have not been extensively studied (Bowers, 1987; Hutchinson, 1988; Olshansky, 1987). The other two modes, the emergent fit mode and the intervention mode, allow researchers to conceptualize and test interventions. Traditional research methods are particularly well-suited for these last two kinds of inquiry (Artinian, 1988).

Philosophically, grounded theory traces its roots to George Herbert Mead and American pragmatism, while its sociological roots go back to Herbert Blumer and symbolic interactionism (Hutchinson, 1988). The latter viewpoint suggests that it is through the social interactions and experiences people have with each other as they address life's problems, in conjunction with the interpretations they put upon these events, that people come to define their "world", thereby creating and symbolizing "meaning" for themselves (Blumer, 1969).

This viewpoint has provided some key assumptions for grounded theory. One assumption is that all people who share common circumstances (e.g., teachers in a program for gifted children) also share social psychological "problems" that grow out of their shared life, even though these problems may not be consciously known or articulated (Hutchinson, 1988). Another assumption is that as people attempt to resolve these fundamental problems, they engage in social psychological processes which are manifested in patterns of behavior (Glaser, 1978).

Grounded theory also shares a number of assumptions and characteristics associated with other approaches classified as qualitative or naturalistic research (Hutchinson, 1988; Sandelowski, Lewis & Harris, 1989). Like these other approaches, grounded theory focuses on context, "lived experiences", patterns of experience, and the critical appraisal of these identified patterns of social interaction (Hutchinson, 1988). It also accepts the notions that: (a) social reality is complex, constructed, and subjective; (b) human behavior is heavily mediated by the context in which it occurs; (c) the research process is an interactive one in which the researcher and the subjects of inquiry (often referred to as the respondents or the participants) reciprocally influence each other; and (d) "reality" or "truth" is best understood by the researcher entering into the subjects' natural environment (Lincoln & Guba, 1985). However, it is distinguished from these other approaches by its unique method of collecting and analyzing data — the constant comparative method (Glaser & Strauss, 1967) — and its de-emphasis of the role of the researcher in co-constructing the subjects' accounts (Rennie, Phillips, & Quartaro, 1988).

Taken together, these underlying assumptions of grounded theory have helped to orient and guide researchers by suggesting the theoretical goals and objectives and the theoretical means for reaching them. They lead naturally to the primary goal of grounded theory which is to "generate a theory that accounts for a pattern of behavior which is relevant and problematic for those involved" (Glaser, 1978, p. 93). They also suggest the main objective, which is to "discover" the core variable or category (often a process) which accounts for most of the variation in the central pattern of behavior participants engage in as they strive to resolve a problematic issue in their lives (Hutchinson, 1988).

These assumptions also suggest methodological principles to guide the researcher using grounded theory. To best understand how the subjects interpret events, and their behavior at both the behavioral and symbolic levels, the researcher needs to enter their "world" (Lincoln & Guba, 1985). Because meaning is derived through social interaction, to fully understand meaning the participants' behavior must be observed and placed in context (Chenitz, 1986a).

Overview of the Grounded Theory Method

The grounded theory approach "provides a method for moving from the phenomenon to a theory in a series of systematic steps which ensure that the developing theory is tied to the data which have been collected" (Quartaro, 1986, p. 2-3). Briefly stated, the researcher using this method systematically and simultaneously collects and analyzes data about a phenomenon in order to discover embedded concepts (called categories). He or she then uses these categories to help: (a) guide further data collection and analysis; (b) reveal the basic structure or process of the phenomenon under study; and (c) develop the conceptual building blocks for the theory gradually emerging from the data.

Although Glaser and Strauss have outlined the general approach (Glaser, 1978; Glaser & Strauss, 1967), their desire to leave the researcher with maximum flexibility (Glaser, 1978) has left a certain procedural vagueness (Hutchinson, 1988). This has resulted in different descriptions of the specific research steps, as well as different emphasis on the available techniques (Chenitz & Swanson, 1986a; Quartaro, 1986; Turner, 1981).

Description of the method is also complicated by the fact that data collection and analysis do not proceed linearly, but occur simultaneously. The process has been described as a "double-back" (Glaser, 1987), concurrent (Quartaro, 1986), or circular process (Hutchinson, 1988). However the process is labelled, attempting to describe it succinctly in writing is difficult because in reality the researcher shuttles back and forth between data collection and data analysis. Mott (1989) has used the notion of the DNA double-helix as a metaphor for describing how the intertwined processes of data collection and analysis reciprocally influence each other.

Before discussing the steps involved in the research process, the four primary strategies used to direct the tasks of data collection and analysis will be examined. These are: the constant comparative method of analysis, theoretical sampling, memoing, and bracketing.

The Constant Comparative Method of Analysis

This is the fundamental method of data analysis (Hutchinson, 1988). Using this method, raw data are first "fractured" and then coded into specific datum incidents (Quartaro, 1986). Through the development of these codes, their constant comparison with other codes, and the use of increasing levels of abstraction, this and later data are transformed in a series of steps into categories and theoretical codes that are eventually "woven" back into a theory "grounded" on the data (Corbin, 1986b; Glaser, 1978; Stern, 1980; Turner, 1981).

Theoretical Sampling

This is the primary strategy guiding data collection. It is:

> the process of data collection for generating theory whereby the analyst jointly collects, codes, and analyzes his data and decides what to collect next and where to find them, in order to develop his theory as it emerges. (Glaser, 1978, p. 36)

The goal in theoretical sampling is to explain the emerging phenomenon in a complete, practical manner. It is based on the need to ensure that there is representativeness in each category. This requires diversity in the sampling to ensure that each category is full and rich so that the full range and variation of behavior for each category is accounted for. Theoretical sampling for a particular category ceases when the category becomes saturated with information – meaning that no new or useful information about it, its properties, or its relationship to other categories can be obtained.

Memoing

This technique serves two main functions. Primarily it is a vital part of the process wherein descriptions of empirical work are elevated to a theoretical level (Hutchinson, 1988). The researcher's spontaneous ideas about the codes, categories, and their relationships to each other are immediately and systematically recorded "in order to capture the initially elusive and shifting connections within the data" (Hutchinson, 1988, p. 136). Premature ideas which may have later value, or thoughts about the similarity of the emerging theory to established theories or concepts, can be noted and preserved (Rennie et al., 1988).

The other main function is the provision of an "audit trail" (Guba & Lincoln, 1985, Halpern, 1983). Such a trail provides a means of tracing the evolving conceptual thinking of the researcher, either for him or herself or for later researchers. It enables the researcher to see any gaps in the developing relationship between theory and data, and it helps to reveal tacit assumptions that may be inadvertently biasing the researcher.

Bracketing

Because of the assumptions grounded theory shares with those other qualitative or naturalistic research approaches noted earlier, the researcher must observe not only the behavior of the subjects but also his or her own behavior. The researcher needs to become aware of his or her own assumptions, values, beliefs, and biases. This is done by "bracketing" his or her own values, so they can be more objectively examined, and will be less likely to distort the perceptions of the researcher as she or he interacts with the data. The process can be assisted by: (a) documenting one's biases, assumptions, and low-level hypotheses at the outset of the research (Quartaro, 1986), (b) keeping a daily journal of personal thoughts and feelings (Hutchinson, 1988), and (c) regularly examining the accumulating memos for clues to unconscious biases (Rennie et al., 1988).

The Research Process

Guided by the above strategies, the researcher moves through a series of steps which transform the raw data into a grounded theory. Keeping in mind that different researchers have conceptualized the process differently, Quartaro's five-step model (Quartaro, 1986) provides a good overview of the various tasks involved. The five steps are:

1. collection of data
2. comparison of data

3. integration of categories
4. delimitation of the emerging theory
5. presentation of the theory.

Collection of Data

The researcher using grounded theory methodology wants to quickly learn what is central and crucial to the phenomenon under investigation (Glaser, 1978). Therefore the initial data sources selected are those which can best illuminate the problem under study. If these sources are human sources, they are chosen because they seem most likely to represent or typify the phenomenon. Usually, they are perceived to be quite similar to each other as well. This is done to maximize the chances that essential information will emerge quickly and clearly (Rennie et al., 1988).

After the constant comparative method is used to analyze the initial data, the tentative findings that emerge will suggest various directions to go for further data collection. The process of collecting new data is guided by the strategy of theoretical sampling discussed earlier.

Comparison of Data

Remembering that data collection and data analysis happen concurrently, the researcher codes, analyzes, or compares information in two ways. One way is by using it for simple description, much akin to a phenomenological study (Giorgi, 1970). Data are analyzed and key vignettes of the participants' experience are selected and presented in order to allow readers to vicariously experience and understand the "world" of the participants.

The other method of analyzing data is by use of the constant comparative method. Raw data are transformed in a series of cyclical steps into a theory "grounded" on the raw data (Corbin, 1986a; Corbin, 1986b; Stern, 1980; Turner, 1981).

The first transformation begins with substantive and open coding, a process in which the raw information is summarized without imposing any theoretical construction on the data. Substantive coding refers to summarizing, or coding with words, the action or event occurring in the setting (Hutchinson, 1988). The code is simply a descriptive label, often using the idiosyncratic language of the participants themselves. Substantive coding based directly on the data prevents the researcher from imposing, intentionally or unintentionally, his or her own preconceived impressions. This helps improve the credibility of the later findings (Guba & Lincoln, 1982). Open coding refers to the coding of each sentence or incident into as many substantive codes as possible to ensure full theoretical coverage (Hutchinson, 1988).

Substantive and open coding results in the data being "fractured" into a number of coded fragments or incidents, called substantive codes. Next, similar substantive codes are "clustered" and given an initial label. Swanson (1986) suggests using "laundry lists" of substantive codes to help identify those codes that are related to each other. However it is done, this initial clustering results in the formation of a substantive category. This category label is at a higher conceptual level that the substantive codes, and so creates a beginning hierarchy of concepts.

Theoretical sampling is then used to clarify and elaborate the categories and continues until all the properties of the categories are identified and saturation occurs. This is done to ensure that there is representativeness in each category. Whereas in the initial sample the focus is on similarity, in subsequent theoretical sampling the emphasis is on diversity – ensuring that each category is full and rich, thus accounting for the full range and variation in each category. Theoretical sampling helps to explain the emerging phenomenon in a fully complete, practical manner. Full sample size will be completed when data saturation occurs, when no new categories are formed. Rennie et al. (1988) report that saturation often occurs after the analysis of 5 to 10 protocols.

Integration of Categories

At this stage, substantive categories are compared for similarities and differences. This means some will be recoded or subsumed by other categories or combined with others to form more new categories. Resulting categories are compared with each other to determine whether there are any relationships between these categories and if there are, what the patterns are among these relationships. The patterns among the substantive categories are identified and then abstracted to a higher level of conceptualization by using theoretical codes. Theoretical codes are theoretical constructs and are derived from a combination of academic and clinical knowledge (Hutchinson, 1988). They subsume and order the underlying substantive categories. They not only help organize the underlying clusters of behavior, but also demonstrate how the clusters are "linked" into the patterns of behavior which account for the various processes occurring in the domain under study.

Next, the relationships among the theoretical codes are examined by using "families of theoretical codes" (Glaser & Strauss, 1978; Swanson, 1986). These are families of conceptual categories which provide terms (e.g. causes, conditions, consequences) that assist the ordering of the relationships between the theoretical categories, and facilitate the formation of the emerging theory.

Delimitation of the Emerging Theory

This step has also been described by Rennie et al. (1988) as the "movement towards parsimony." By continuing to use the four strategies of grounded theory the more central categories finally saturate. Eventually, the core category that both integrates and accounts for most of the variation in the data is "teased out" and saturated. The core category is "usually a hypothetical construct, a recurrent theme in the data around which the other categories constellate and which becomes the keystone of the theory" (Quartaro, 1986, p. 7). Memoing, important throughout the research process, assumes particular importance at this stage by helping to integrate the findings and lay the groundwork for the presentation of the theory.

Presentation of the Data

In grounded theory, writing the theory itself is also part of the research process (Chenitz & Swanson, 1986b). The seeds of the final report are found in the memos that have been written throughout the study. In the earlier stages, memo writing and sorting helped point out areas needing clarification, refinement, or verification, and lead to further data collection. Now, at this stage, as memos are sorted and re-sorted, ideas for writing are organized and clarified. When the sorting is complete, the researcher begins to write the theory with the core category as the central focus (Hutchinson, 1988).

Glaser (1978) identifies two forms of theory: substantive theory and formal theory. Substantive theory is a theory developed for a specific area of empirical inquiry, e.g., a treatment program for emotionally disturbed adolescents. Formal theory refers to theory developed for a more conceptual area of inquiry, e.g., deviant behavior, socialization, treatment processes, or authority and power. Glaser says both of these theories may be considered "middle range." This means "they fall between the 'minor-working hypotheses' of everyday life and the 'all-inclusive' grand theories" (p. 144).

If the writing of memos throughout the analysis has been properly conducted, the writing of the theory happens relatively quickly (May, 1986). Sometimes the volume of data obtained is overwhelming. Corbin (1986b) suggests using diagrams to help obtain an overview, while May (1986) suggests writing a one-or-two page summary which can then be used as a "map" for the development of the research report.

In writing and presenting the theory, the writer wants to ensure that the theory is dense and clear (May, 1986). Density has three aspects: scope, complexity, and integration. Scope and complexity refer to the breadth and depth of the theory. The theory is dense if it possesses a few key theoretical constructs and a substantial number of properties and categories (Hutchinson, 1988). The theory is more dense if the categories are well integrated - meaning they are systematically related to each other and fit into a tight theoretical framework. Density helps to improve the transferability of the study - i.e., it increases the likelihood that the outcomes or conclusions reached in the study can be applied or transferred to another setting (Guba & Lincoln, 1982).

In demonstrating clarity, the writer enables the reader to easily ascertain how well four criteria pertaining to the quality of the theory are met:

1. The theory should fit the data. The codes should spring naturally from the data. The data should not have been "forced" into the codes. Readers of the theory should be easily able to see this fit. A common test of fit is the reaction of the participants (May, 1986).

2. If the theory clearly explains major behavioral and interactional variations in the data, it works. It works even better if it can predict what will happen given certain conditions and certain variables (Hutchinson, 1988).

3. A theory has relevance if its core variable usefully explains the essential processes going on in the setting as the participants try to resolve their fundamental problem (Glaser, 1978).

4. Finally, a good theory is modifiable. Although basic processes are relatively constant, social life is not. Therefore a good theory is able to accommodate to evolving variations. A flexible or tractable theory is able to adjust to new conditions and is thus able to maintain its relevance (Glaser, 1978).

Implementation of the Study

The Research Setting

A residential treatment center (RTC) for emotionally disturbed adolescents provided the setting for this study. The program is located in a 10-bed, free-standing, semi-secure building. It is part of a larger, community-based program which employs a continuity of care model (Whittaker, 1979). As such, it provides hospital assessment and back-up, together with day, evening, and follow-up programs. The residential program was specifically developed to:

> Address the problems of the multiproblem adolescent with poor community and family supports who has been exposed to unsuccessful, often repeated interventions. These [adolescents] often have histories of extensive child welfare involvement, multiple failed placements, and are considered to be high risk cases. (Blackman et al., in press)

Admission into the program assumes the adolescent is unable to be treated on an outpatient basis. Treatment is multimodal and based on a modified therapeutic community format. The staff is multidisciplinary and includes a full range of mental health specialities. The program is open-ended with the usual length of stay being about four to six months following which the successful residents may graduate to one of the affiliated community programs or be referred to an appropriate alternative agency.

The Participants

The primary participants in this study were adolescents who had completed the residential treatment program and demonstrated successful long-term outcome. For the purposes of theoretical sampling, some adolescents who either had just completed the program or who had not successfully completed the program were also interviewed. Staff were occasionally consulted to clarify information obtained from the adolescents, their treatment records, or field observations made by the writer.

The initial sample. Three adolescents were selected for the initial interviews from a pool of adolescents who in the opinion of the Director, senior RTC staff, and the adolescent's last therapist represented the kinds of adolescents who had completed the treatment program and successfully returned to live in the community. The criteria for selection of these adolescents were that:

1. They had successfully completed the residential

treatment program as adjudged by the Director and senior staff at the RTC.

2. They had been discharged for at least one year from the RTC.

3. They were perceived by their last therapist, their parents and themselves to be living successfully within the community and no longer in need of residential treatment.

4. They had, in the opinion of their present or last attending psychiatrist, the mental competency to provide informed consent and the mental ability to reflect upon and articulate their experience as a resident in the RTC.

Demographic information revealed that one participant was living in an intact two-parent family, one was living in a re-married family, and one was living in a foster placement. One participant was male, and two were female.

Data Collection

Grounded theory methodology requires that a variety of data from a variety of sources be collected during the research process in order to ultimately generate a theory that is grounded in the data. Data collection began after the researcher assumed the role of participant observer (Davis, 1986). Data were collected through observation of adolescents and staff in the treatment program, informal interviews with adolescents and staff, and reviews of the medical records and the professional literature.

Data regarding the primary participants' subjective experiences and perceptions were obtained through informal or minimally structured interviews (Chenitz, 1986b) with the participants. Data regarding the treatment of the participants, including their presenting problems and course of treatment, were obtained from the participants, their medical records, and the staff involved in their treatment.

Descriptions of the residential treatment center and the treatment process within it as seen through both the eyes of the subjects and the eyes of the researcher were also collected. Lastly, data from the professional literature germane to concepts emerging from the incoming data were also obtained.

Initial interviews were only with participants who had completed the treatment program. The purpose of these interviews was to determine: (a) the participants' experiences of being involved with the treatment program and (b) the perceptions they had formed about the treatment program.

Initial questions were relatively non-intrusive and open-ended and were designed to stimulate discussion: e.g., "What was your experience of being in the program?" Later questions were more focused and were designed to surface those experiences or aspects of the program participants found most useful: e.g., "What about the program did you find useful?"; "What experiences were most beneficial to you?" Other questions were then asked for the purpose of clarification or elaboration. Initial interviews ranged from 1 to 2 hours in length.

After the three initial interviews were analyzed, nine more interviews were conducted for the purposes of theoretical or purposive sampling. Four of the nine interviews were conducted with adolescents who also met the initial criteria for selection. However, five interviews were conducted with adolescents who had either just completed the program (two adolescents) or had not demonstrated sucessful long-term outcome according to the criteria of the program (three adolescents). These nine interviews had a more defined focus. They were conducted to clarify and elaborate themes that emerged from the initial interviews and to ensure that data saturation was achieved. Five of the nine interviews were conducted before it appeared data saturation was complete. The last four interviews were conducted to ensure data saturation had been achieved. While these last four interviews did not yield any new categories they did in some instances provide better articulated examples of categories already identified. As the nine later interviews were more focused, they generally took less time than the three initial interviews.

After a participant's consent to participate in the research project was obtained, interviews were conducted in a face-to-face format. They were audio-taped and later transcribed onto typed manuscript.

Permission was obtained to examine the adolescents' medical records in order to access demographic and background information as well as information about their presenting problems and course of treatment. Observations about the treatment environment (i.e., the context) were stored in field notes.

The professional literature was reviewed twice during the course of the study. Initially the literature was used to give the study background and to explain its significance and proposed benefits. When the analysis was complete, the literature was reviewed again so that the emergent theory could be presented in the context of other work (Chenitz, 1986a).

Data Analysis

Data analysis was performed on the transcribed verbatim interviews. Following the general steps presented earlier, the transcripts were examined line-by-line. Data were described or summarized into substantive codes. Using the strategies presented earlier, obtained data were transformed from raw data into categories and theoretical constructs.

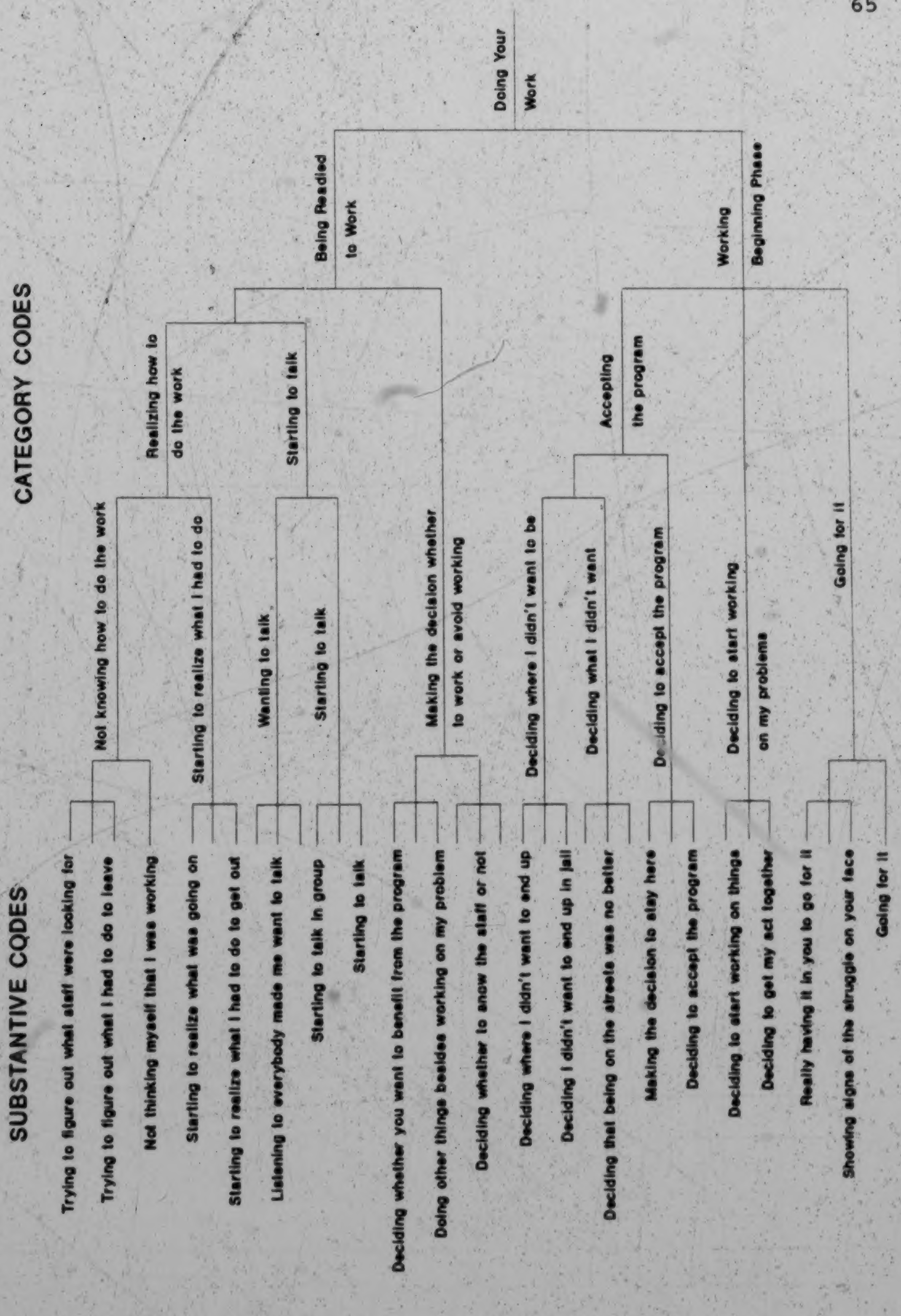

SUBSTANTIVE CODES
CATEGORY CODES
Trying to figure out what staff were looking for
Trying to figure out what I had to do to leave
Not thinking myself that I was working
Starting to realize what was going on
Starting to realize what I had to do to get out
Listening to everybody made me want to talk
Starting to talk in group
Starting to talk
Deciding whether you want to benefit from the program
Doing other things besides working on my problem
Deciding whether to snow the staff or not
Deciding where I didn't want to end up
Deciding I didn't want to end up in jail
Deciding that being on the streets was no better
Making the decision to stay here
Deciding to accept the program
Deciding to start working on things
Deciding to get my act together
Really having it in you to go for it
Showing signs of the struggle on your face
Going for it
Not knowing how to do the work
Starting to realize what I had to do
Wanting to talk
Starting to talk
Making the decision whether to work or avoid working
Deciding where I didn't want to be
Deciding what I didn't want
Deciding to accept the program
Deciding to start working on my problems
Going for it
Realizing how to do the work
Starting to talk
Accepting the program
Being Readied to Work
Working Beginning Phase
Doing Your Work

Figure 1. Illustration of coding and clustering using dendrogram method

Figure 1 illustrates how statements from adolescents were coded and then clustered into categories and constructs. The collection of new data was "modified as directed by the advancing theory" (Field & Morse, 1985, p. 109).

This process of systematic and simultaneous data collection, coding, and analysis eventually led to the discovery of two core categories which helped to explain the central problem participants face while in the RTC and how they resolve this problem. These core categories became the keystone for the theory presented later in Chapter six. Observations gathered while the researcher was in the role of participant-observer at the RTC were used to provide commentary and to illuminate the context in which the participants addressed this central problem.

Ethical Considerations

Every effort was made to conduct this inquiry in an ethical manner, taking into account the considerations for ethical qualitative research as suggested by Archbold (1986) and Munhall (1988). Only adolescents deemed competent by their attending psychiatrists to provide full and informed consent were allowed to participate. Every participant in the formal interviews was informed about the nature of the study before his or her interview began. The potential risks and benefits of participation, whom the data would be discussed with, and how the data would be obtained, used, stored, and presented were discussed.

Participants were protected so that no identifying data linking any specific individual to the published study could be discerned. All questions involving their rights to freely participate or withdraw at any time from the study without penalty were satisfied before they were allowed to participate. Lastly, a signed letter of consent (see Appendix) was obtained from each participant verifying that all of the above points had been discussed and explained to their satisfaction. Results of this study were made available to some of the participants to help determine if the theory generated from this study fit the data.

Risks and Benefits

Although any intervention with human subjects involves risks, the potential for harm here, in this researcher's opinion, was minimal. Interviews were voluntary and confidential. The majority of the interviews were with adolescents no longer involved in the treatment process and whose treatment experience was positive. The interviews were informal with only minimal structure, leaving adolescents with the freedom to determine how much they wished to disclose during the interviews. One possible risk envisioned earlier by this researcher concerned those adolescents who were in treatment at the time of their interview. Although it was earlier anticipated that the resources present in the treatment environment would be more than adequate to deal with any disruption that might occur as a result of being interviewed, the problem remained hypothetical - nothing disruptive happened.

The greatest ongoing risk for participants is breach of confidentiality resulting in loss of anonymity. However, several safeguards minimize this risk. Pseudonyms have been used so that the true identities are known only to the researcher. No identifying information linking a participant to the study has been published. Consent forms, tapes, transcripts, and notes have been kept in a locked cabinet. Following the completion of this project, all audio-tapes will be erased. Transcripts and notes will be made available only to qualified researchers after appropriate arrangements have been made.

CHAPTER FOUR

RESULTS and DISCUSSION: DOING YOUR WORK

> R: What do you think kids are supposed to do in here?
> Cl: Um, work!
> R: Say some more about that.
> Cl: Trying to express the way that you feel and what's going on, like ah, like what kind of problems you have. . . because like you can't bottle it all up inside and stuff because some day you'll blow up.

* * *

> R: You just used the word "help." What about this program helped you, would you say?
> Cl: Personally, I felt it kept me alive (pause), for you know, and it helped me deal with problems that were inside that I've never been able to talk about or tell anybody before.

* * *

In this and the following chapter the perceptions of the adolescents (usually referred to as the "kids" by the staff and themselves) of their experiences with the residential treatment program are presented. In conjunction with their statements (unless stated otherwise, all of the following quotations are from successful adolescents), commentary will be provided by the writer. This commentary is based on information gathered by the writer in his capacity as either an employee of the RTC or as a researcher while implementing the present study. Clinical observations, field notes, and information gathered from staff and medical records are the primary sources of this information.

Guided by grounded theory methodology, analysis of the interviews of the selected adolescents eventually led to the identification of two central themes which seemed to emerge from their narratives. One theme has to do with the notion of "work"; the other has to do with the notion of "help." Although these themes might seem rather commonplace, and perhaps, taken for granted by us, to the adolescents in the program they appear to have acquired much significance. These two themes were determined to be reflections of what Glaser and Strauss (1978) refer to as Basic Social Psychological Processes (BSPPs).

This and the following chapter will show how most of the adolescents' perceptions about their experience in the residential treatment program can be incorporated into two BSPPs – one in which the focus is primarily on the adolescent, entitled "Doing Your Work," and another which is more interactive, entitled "Being Helped."

While it is possible that these two BSPPs could have been subsumed into a larger process such as "Resolving Your Problems," "Becoming Normal Again," or "Getting Out," it was decided that this would detract from the importance the adolescents seemed to assign to these two BSPPs. Therefore this chapter and the next one will examine these two processes in more detail.

This chapter will describe the stages in the BSPP of "Doing Your Work" that adolescents pass through as they progress through the treatment program. Describing the components of this BSPP results in the formation of a substantive theory (Glaser, 1978) about working (in a social psychological sense) in an adolescent residential treatment center. Chapter 5 will repeat the above procedure for the BSPP of "Being Helped," and results in the formation of a substantive theory about being helped in an adolescent residential treatment center. Chapter 6 will then integrate the findings of other researchers and theorists with the findings of this study in order to develop a more formal substantive theory (Glaser, 1978) for adolescent residential treatment that will meet the research goals stated in chapter 1. A model illustrating the components involved in actualizing these two BSPPs will also be presented in chapter 6. It is hoped that this model can be used to offer guidance to those treating disturbed adolescents.

Doing Your Work

In examining the transcripts of the adolescents, it was discovered that the word "work" and its derivatives (e.g., working, worked) appeared in a variety of phrases used by the adolescents. For example, they speak of "working on your problems," "working out your problems," "working through your problems," finding the program to be "hard work," "working in group," "having the group work or not work," "working at your own pace," "working up the level system, "working your way through the program," "having done my work," and "working things out.

The adolescents used the word "work" as a noun, adjective, and verb at different times. As a noun, they used the word to refer to exertion or effort directed to produce or accomplish something, – "It takes hard work to succeed in the program" – or to something to be made or done, like a task or undertaking – "I did all the work I thought I needed to." As an adjective, the word appeared in phrases like "That was the main work group." As a verb, it was used to suggest doing work or labor, – "You have to work out your problems" – to describe the effectiveness of the program – "The program works" – or to attaining a specified condition by continuous efforts – "You have to work through your problems to succeed." A less common use as a verb referred to undergoing treatment by working in a given way, e.g., "The group works slowly."

One of the most important ways the word "work" is used is in the phrase "work out," meaning "to solve a problem." In the language of the adolescents, "working things out" often appears to be synonymous with "solving your problems." However, working out your problems does not just mean a cognitive or behavioral solution. It also refers to a process. It means taking such steps as "opening up," "dealing with your feelings," and "dealing with your problems." The adolescents emphasize that working out your problems cannot just mean coming to a cognitive or behavioral solution. There must also be an emotional resolution. This means the powerful, often painful feelings associated with a particular issue must be expressed to allow full resolution.

Another aspect of the word "work" appears when it is contrasted with its opposite - the word "play." The adolescents see their task as one of work, not play. Perhaps it is no coincidence that adolescence is typically seen as the time to say goodbye to the childhood world of play, and to enter into the adult world of work. And yet, as shall be seen later, there is something of a paradox here.

In light of the many different ways that the word was used by the adolescents, it was decided to create a category called "Doing Your Work" to identify that BSPP associated with the theme of work. The term "Doing Your Work" is intended to capture the variety of ways that the word is employed. The term implies that there are unique tasks for each adolescent that need to be completed in order to achieve his or her goals, and that effort and persistence (literally blood, sweat and tears sometimes) will be required to succeed. It implies that adolescents must take responsibility for completing their tasks, and that they must take their tasks seriously. It also implies that there is a process in which adolescents must engage in order to accomplish their tasks. Lastly, it implies that by engaging in this process adolescents have a real opportunity to resolve their problems.

Although the BSPP of "Doing Your Work" will be examined separately in this chapter from the BSPP of "Being Helped," it should be kept in mind that in reality the two processes are really very much inter-connected. The metaphor of the entwined DNA/RNA molecules mentioned earlier is apt.

There are many different ways that the BSPP of "Doing Your Work" can be examined. One of the most logical ways is to track it along a temporal dimension - to follow it as it unfolds over time, and to examine the sub-processes that weave into it. Another way is to use the 6C's method suggested by Glaser (1978). This method allows the researcher to organize sub-categories, clarify their relationship with each other, and then develop theoretical links between them. This chapter will attempt to incorporate the strengths of both methods. Overall, a temporal dimension will serve as a backdrop. In this way, one can obtain an understanding of the phases and stages adolescents pass through as they enter, reside in, and leave the treatment program. Summarizing this information using the 6C's method will help to succinctly explain why adolescents come into treatment, where the therapeutic events happen, the context in which they occur, and the consequences of their occurrence.

Starting with the temporal dimension, it appears that the process of "Doing your work" can be broken down into three overlapping phases: Being Readied To Work, Working, and Completing The Work. Figure 2 outlines the stages and steps that comprise these three phases.

The first phase, Being Readied To Work, covers the time-span from admission into the unit until the adolescent makes the decision to work on his or her problems. The second phase, Working, covers the time-period during which the adolescent is struggling with his or her problems and trying to resolve rather than avoid them. The last phase, Completing The Work, is a time for integration during which the adolescent consolidates new ways of being and begins to disengage from the people in the treatment program.

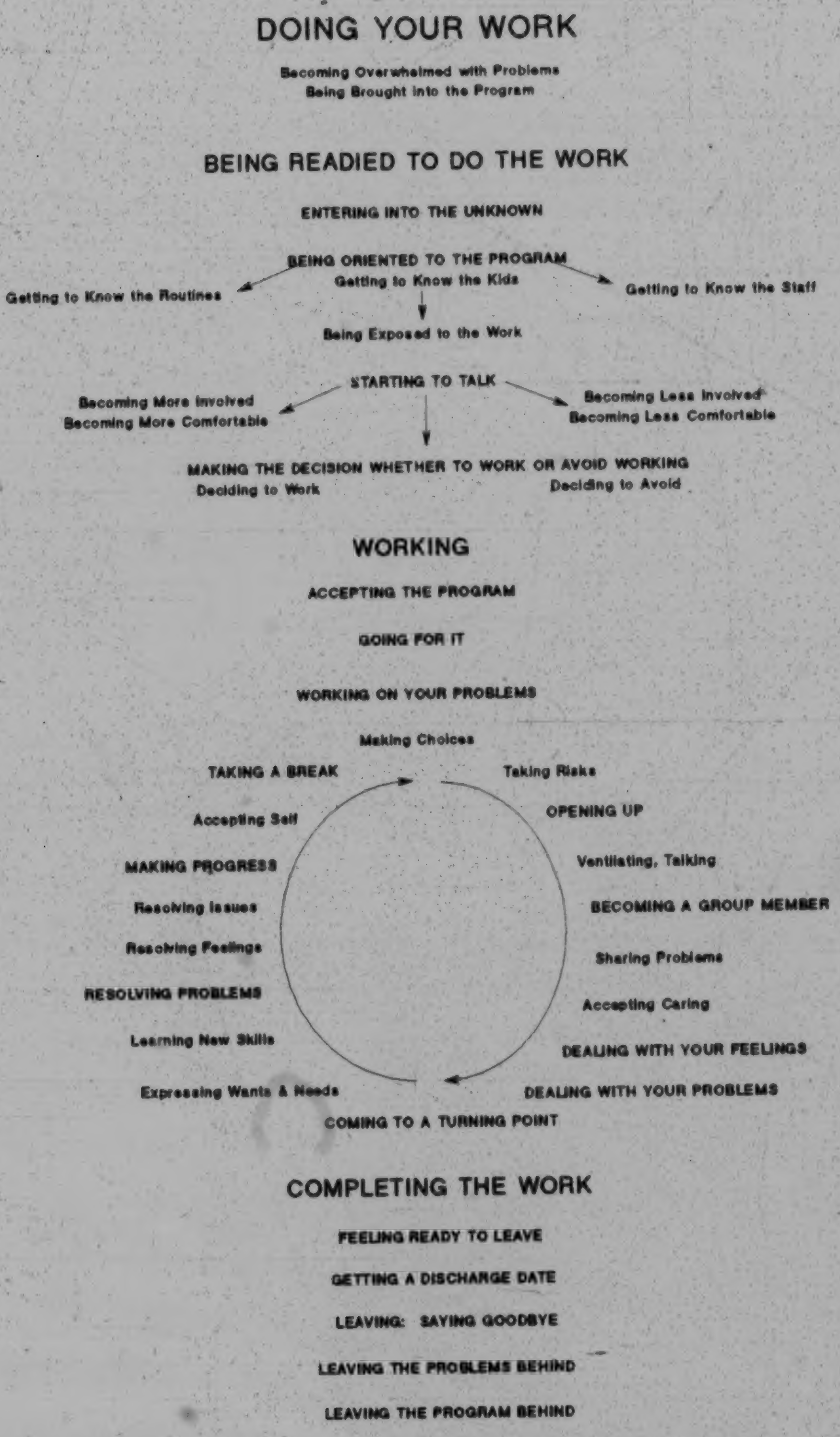

DOING YOUR WORK
Becoming Overwhelmed with Problems
Being Brought into the Program
BEING READIED TO DO THE WORK
ENTERING INTO THE UNKNOWN
BEING ORIENTED TO THE PROGRAM
Getting to Know the Routines
Getting to Know the Kids
Getting to Know the Staff
Being Exposed to the Work
STARTING TO TALK
Becoming More Involved
Becoming More Comfortable
Becoming Less Involved
Becoming Less Comfortable
MAKING THE DECISION WHETHER TO WORK OR AVOID WORKING
Deciding to Work
Deciding to Avoid
WORKING
ACCEPTING THE PROGRAM
GOING FOR IT
WORKING ON YOUR PROBLEMS
Making Choices
Taking Risks
OPENING UP
Ventilating, Talking
BECOMING A GROUP MEMBER
Sharing Problems
Accepting Caring
DEALING WITH YOUR FEELINGS
DEALING WITH YOUR PROBLEMS
COMING TO A TURNING POINT
Expressing Wants & Needs
Learning New Skills
RESOLVING PROBLEMS
Resolving Feelings
Resolving Issues
MAKING PROGRESS
Accepting Self
TAKING A BREAK
COMPLETING THE WORK
FEELING READY TO LEAVE
GETTING A DISCHARGE DATE
LEAVING: SAYING GOODBYE
LEAVING THE PROBLEMS BEHIND
LEAVING THE PROGRAM BEHIND

Figure 2. Steps in the BSPP Process "Doing Your Work"

Being Readied To Work

Entering into the Unknown

> When my social worker told me I was going there, I was scared. I heard lots about the place and all bad people went there. I got ready and got all my things ready and I was prepared to go physically but not emotionally. I didn't get a chance to meet anybody the first day I was there. I was moved in the very first day. I didn't go through the walk tour or anything. The first day they took away everything I had. Everything was gone, my clothes, all of my personal belongings and that made me feel very insecure for I had nothing of my own.

* * *

> When you get here you feel really mad. Like I felt mad, I got here and I was so pissed off. . . "I can't believe I'm going to be locked up."

* * *

> When they first come here. . . they don't know what is going to happen to them. It's almost like the unknown and I think that after a while when they find out the rules and everything then they become more comfortable here and they're not scared. . .

* * *

> When I first came into the program it was a real, real shock and so much structure, and rules, and I really hated it . . .. I wanted to do anything I could to get out, and I begged my mom, and I asked my mom "Please take me out, please take me out."

* * *

> I just hated everybody and thought everyone was wrong.

* * *

Admission into the RTC is a difficult experience for most adolescents. This event, the first of many stressful experiences to come, usually evokes intense reactions, even though they are not always readily apparent. While there may be an underlying sense of relief about no longer having to struggle alone against overwhelming problems, there are often profound feelings of sadness, fear, or anger over real or threatened losses (especially over the loss of familiar support systems and the freedom of movement) and in anticipation of the unknown experiences that lie ahead. Admission is usually perceived by adolescents as a sign of failure, so the initial impact on their self-concept or self-esteem level can be devastating. Exchanging one's clothes for pyjamas and giving up familiar items of belonging only exacerbates already painful feelings. Thus, it was not surprising that almost without exception the adolescents reported negative feelings about having to be admitted into the program. Being very scared or very angry, the classic flight-fight response to a perceived threat, was the norm.

Being Oriented to the Program

> Like I said, I came out of that room and it was, I just got my pyjamas, like this is my first introduction to the unit and I was just going to go for a walk through it and this guy turned to me and said "Hi, my name's [S.], I'm going to be your personal key worker. Positive, enthusiastic, um, goofy, but for people to work here you have to be goofy to an extent. What I mean by that, you have to very, um, chipper, you know what I mean, you have to be really pumped and it can be kind of a so pumped up you're almost optimistically blind.

* * *

> [You're] by yourself when you come in. All these kids know each other for maybe months and you're sitting there and they're all wondering why you're here and they all want to know. . .

* * *

> I was given a teddy bear and that really pissed me off because I have never slept with stuffed animals in my whole life.

* * *

> When you first come in here you get a [teddy] bear and I used to throw it around. I don't want this crappy old bear, what's it going to do for me. . . I just hated it. . .

* * *

> But after I got in here and I got used to [the program], I started to realize what was going on and what I had to do to get out.

* * *

As an adolescent is introduced by staff and other adolescents to the scheduled events, and as they learn the rules and morés of the institution, most adolescents experience a kind of paradoxical reaction. On the one hand they begin to feel a little more comfortable, a little more "at home." On the other hand they began to feel even more anxious as it becomes clear that they didn't leave their problems behind and as they begin to experience "withdrawal" from their old support systems.

* * *

> R: Um, it almost sounds like uh in some ways drugs become much more important to you than the relationships do, when you start using drugs.

> Cl: I need them. Like I have to have them, like I'll do anything for them. And like drugs are really powerful.

* * *

> It's kind of lonely at first because you miss your parents, and I was so young, and I didn't know if I could survive without my mom back then. . . .

* * *

Loss of support, whether it be from drugs and the other "druggies" involved in this kind of lifestyle, or from parents who, while often substantially less than ideal, still provide the only emotional nurturance and stability the adolescent has been able to depend on, can be terrifying. Feeling totally alone is a common feeling at this stage.

* * *

> I did get a teddy bear, and actually I got two of them, and I really liked them. It was really easy for me to a, like when I missed my mom I could just talk to my teddy bear and cuddle up to him. It's, it was good having a teddy bear because you were never, well you could be lonely but you'd have something there to hug. If you got upset in one of the groups you could carry your teddy bears around with you.

* * *

In order to provide a transitional object (Sosin, 1983; Winnicott, 1953) which will help them let go of their old support systems enough to enable them to develop a new support system, all adolescents are given a teddy bear upon admission. However, as the earlier quotations show, this is not always appreciated.

Starting to Talk

> Every morning around 9:00 we had to get our teddy bears, or grab a teddy bear, or whatever you had to do, and then we would go downstairs to the group room.

* * *

> The first few groups I sat there and didn't do anything and then after awhile I kind of listened to everybody which made me want to talk, sort of, and so I just started talking. . .

* * *

> You have a million and billion feelings bottled up and starting to talk about them, and starting to bring them out in the open, and deal with them is really hard because you have so much feelings, just incredible amounts.

* * *

Within a day of arriving, new adolescents begin attending the large and small group sessions, including the main group session referred to as "large group." This group meets once a day except on Friday, when there is an extra session signalling the "official" end of the work week. Other than providing a cursory self-introduction, most adolescents usually "observe" this group a few days before making any attempts to join the group discussions. Starting to talk brings about mixed results. Although it allows adolescents the opportunity to join a group of their peers, it also makes denying the existence of problematic issues or feelings more difficult. Continuing to remain silent about troubling thoughts and feelings, which the adolescents describe with phrases like "bottling it up," or "keeping it locked up inside," becomes harder.

* * *

> Sometimes the therapist can really get you pissed-off . . .and in group you could get really mad. So you just go up to a TR room, get the punching bag and do some butt-kicking on [it] and that would get your. . ., it got my feelings out. It's better than going and hitting the staff and getting put out of group. Because that way you don't have to worry about punching anybody or hitting someone. . .

* * *

Often adolescents will resolve their difficulties with expressing their feelings in words by displacing their frustrations about internal conflicts onto "safe" targets, either objects or people (including themselves) inside or outside of the group situation. Expressing these internal conflicts in deeds rather than words constitutes the familiar process known as "acting out" (Brown, 1978; Rinsley, 1980). A punching bag placed in a "safe room" provides a transitional object for adolescents unable to express feelings in words or unable to express feelings directly and appropriately to the person they're angry with.

Making the Decision Whether to Work or Avoid Working

> D. is a guy who really had it in him and he knew it all along but he didn't want to go for it, you know what I mean, you always saw that struggle on his face.

* * *

> R: Why would you want to avoid working through things, facing things, feelings. . .

> Cl: . . .because it's painful, it's scary as hell, it threatens your entire soul. It took six months before I even realized, before I even recognized the problem.

* * *

> I said "I 'll forgo that goodness to avoid the pain. . . the pain that will. . ., the initial pain will be too great and the goodness I can't even look beyond, I can't look to that stage, look beyond the actual pain.

* * *

> I decided that I didn't want to be where my uncle is, so I just said to myself "Well if I don't want to be there then I should get my act together".

* * *

> I knew for one thing that I didn't like to be cooped-up in these places, I didn't like to be some, some psych-file. So that's one reason, I said "Well I'm going to have to do this right, I'm going to have to start working on these things or else I'll never get out, I'll never truly get out."

* * *

The longer adolescents stay in the program, the more they are propelled towards a "choice point" where a decision has to be made about whether or not they intend to seriously work on their problems. However, it often appears that they will do everything they can to avoid making this commitment.

* * *

> I said "This is it, I've got to get out of here." So I ran to the door, I pulled the fire alarm and I kicked the doors open. . . I was frantic, I was frantic, I didn't want to go outside to sit on the stupid bench, I wanted to go outside and see my friends. So I AWOLED for my friends which didn't do me very much good.

* * *

> You can definitely avoid your problems, you can just do the "jump the hoops," the ones that they set up for you and that's it, leave. For me I jumped through the hoops my first time, I think I faced up to a lot of my problems but I didn't bite into most of them . . . .

* * *

> I remember sleeping all the time, all the time I was sleeping. It was my way of, I guess avoiding everything. Every breathing moment I had a chance – we had 15 minutes to, till lunch – on the sofa I'd be asleep . . . .

* * *

While it is not possible to passively decide to work on one's problems, adolescents can decide to be either passive or active about their decision to avoid doing their work. Active avoiding might take the form of elopement (called AWOLing), developing or supporting a delinquent sub-culture (ranging from simple "pairing" with another patient to actually planning and carrying out a "riot"), or becoming a "model patient." Passive avoiding might take the form of withdrawing, sleeping, or the lethargic compliance similar to the "learned helplessness" phenomenon (Maier & Seligman, 1976).

Aggressive resistance against the program almost always leads to eventual capitulation on the part of an adolescent. The adolescent is simply unable to resist the combined pressure of pro-social peers and staff as they demand positive change from him or her. Eventually the adolescent either gives in or elopes. Very rarely, an adolescent, usually a heavy drug-user, will be asked to leave. These latter adolescents appear to be beyond present forms of help, because it appears that their normal craving for human contact has been completely usurped by an unremitting craving for drugs. These adolescents are often particularly good at "conning" the staff into thinking that they are working. The adolescents use phrases like "snowing the staff" or "jumping the hoops" or "brown-nosing" to refer to this kind of behavior. Thus as they move into the next phase of the process, it is not always easy to tell, initially, whether they are working or pretending to work.

Working

Accepting the Program

> The cross-roads occurred when I stopped calling my mom and threatening and saying "I'm going to come home and shoot myself", that's when I stopped, and that's when I accepted the program, basically. I can't say I enjoyed it, I can't say I, whatever, but it was a stage. . . where. . . I was not rebelling as much. . .

* * *

> I guess after a while I thought of it as a I don't know, taking half a year, four months or whatever out of my life to help save my life wasn't really that long of time.

* * *

> I said "I know what this feels like, I know how good a good session of talking and being able to communicate with my parents and with people in group is." I knew how good that felt, so I said "I'm going to start doing this more often, I'm going to start working at this." So that's the second reason I said "O.K., I'm getting started, I'm getting off, getting off my ass and stop lying to these people."

* * *

> I thought that the only way to get out was to actually open my eyes and look at the program, maybe they would do something, maybe they were doing something right.

* * *

The adolescents are not always fully conscious of making the decision to work with the program instead of against it, but at some point in time they realize they have to put effort into their work if they are to succeed.

Going For It

> You have to get used to it and like "go for it." If you're going to be there you might as well. . .

* * *

> If you want, you can come out of this [the difficult life situation the adolescent is struggling with], if you really want, but you have to want to, and you have to dig deep and don't sell yourself short. [advice for a new kid]

* * *

When adolescents make the decision to seriously address their problems, getting down to "doing work," in one sense, becomes much easier. They will usually have a reasonable idea of what needs to be done from having watched and listened to other adolescents. Assistance is usually there for adolescents willing to take the risk of bringing their problems out into the open. And there is continuous pressure to "get it out." In a way it's like running the gauntlet. Once the decision is made to do the work, it's best to keep moving as best one can because slowing or stopping only prolongs the painful process.

Working on Your Problems

> It's really hard to deal with your feelings and it's really hard to let everyone know who you are, and what's happened to you, and for a while, for a period all I did was cry one week straight, all I did was cry, it's really hard work, you know I. . . Sometimes it was easier to just bottle it in and just pretend it wasn't there than to bring it all up and remember everything over again.

* * *

> R: . . .tell me what 'working on your problems' means in your mind.
> Cl: I think it means knowing what your problems are at first, having. . . thinking about something and you start crying, or you have to figure out what that problem is because you're crying for a reason. I used to think I was just crying because there was nothing better to do. . . I was just sad, you know I never used to think why I was being sad and I don't know how, how I figured it out (chuckle). I'm still kind of astonished but I did have the kids, and I did have myself. . .

* * *

> I guess I started working in the program, talking a bit more in groups. It was really hard, I was really frightened at first, I didn't want people, I didn't want to let people in to know me, who I was and what had happened to me, um, but eventually it got easier and easier.

* * *

> There was different aspects of working. There was working in group, working to share your feelings, working to encourage others to share their feelings, working to listen to others express their views and opinions, working to accept criticism, working to accept praise, working to give criticism and give praise to others, working to learn how to interact with other people.

* * *

> Like I say, the program did a small bit, like they kind of guided me along, put the groups in my path, the people in my path, the therapist, but I said "I did most of the work, me and my family."

* * *

As the above quotations indicate, much is involved during this stage of the process. Having tentatively begun to talk, and having made the decision to take on the responsibility of "doing your work," each adolescent must now find a way to resolve his or her problems. Adolescents refer to this stage with phrases like: "working on your problems," "working out your problems," and "working through your problems." There are many steps in this important stage. The next section will look at the major ones.

Opening up

> [When asked to clarify what the "it" means in the phrase "It's so overwhelming. . ."] "It" boils down to, in general, two things - confronting your problems but in turn confronting them with someone there. I mean you might know what your problem is, you might admit to being an alcoholic, but you said that in your head, but when you admit it to someone and verbalize it, then you're leaving yourself, like you're opening up and you're putting your trust in that person and "it" is, I guess, is going through the process or the action of trusting someone and opening up to them.

* * *

> He pushed me really hard by really just sort of turning away from me, and that made me angry and it made lots of feelings come out. So in a twisted unhappy sort of way it helped but that first month it was really hard to talk but the kids brought it out of you. They really encouraged you and you really had to look deep down inside of yourself.

* * *

> It helped me to come up front with my feelings. When I came in here I was mad at the world and they helped me find out more who I was mad at. They made me talk about my feelings.

* * *

> . . .one basic idea was to express all of your feelings about everything that had happened in your life and deal with all of the painful issues. There was some pretty tricky ways in how they got you to deal with it. Like sometimes they'd provoke you so you'd blow up and get angry, which you know, actually after you blew up, and got all angry, and screamed your guts out you'd feel better after because you got a load of anger off your chest.

* * *

As the staff and the other adolescents apply pressure and offer encouragement (aspects of "Being Helped") to an adolescent to "open up," the adolescent is helped to bring out his or her problems. Often this process begins by ventilating long-repressed feelings or transference feelings. Expressing the latter enables adolescents, who may never really have had permission to express feelings before, to begin expressing feelings towards "safer" people – people who do not present as much threat should this process of opening up prove dangerous. When adolescents have some positive experiences with opening up, they find that not only does it enable them to really begin the process of working out their problems, but paradoxically, it also helps them to become both more trusting of others and more comfortable in the program.

Becoming a group member

> When you're going through the process of working everything out, you have to become a group and you have to gain each others trust and get along because, you know, one or two people fight, they start calling names and they start attacking people when they are trying to bare their soul and then before you know it the morale drops and it just falls apart instantly, and one person can do that to a whole group. It's, I mean you have to be a group and it might sound kind of Machiavellian how you work to become a group and then once you're a group and once you've solved your problems you know, it doesn't matter what they say. . .

* * *

> At one point I turned from all these negative comments, from cutting everyone down to being totally supportive. I mean I was like their fa. . ., their older brother or their older friend or their dad or whatever and everybody I supported, I mean, when I saw someone being a jerk I'd tell them to grow up. I mean I did that generally for two reasons – to help them and also to help me. The more progress the whole group makes the more you make and the faster you get out of here.

* * *

> I thought that our group was so close that, I remember everybody was so close in our group, for about for two months nobody new came in and nobody new left. Our group was just so close it was like, we could of been in separate rooms forever and still of felt caring for each other.

* * *

As adolescents open up, they are simultaneously being accepted into the group and bringing themselves into the group. This brings about another situation with mixed blessings. Although they are in a better position to benefit from the caring of a working group, now they must also take more responsibility for how well the group is working. If the group is working well, then knowing that they have the group's caring will help them to feel more secure as they prepare to move forward. Using the group for support and its members as role-models the adolescents can then experiment with the next steps of the process.

Dealing with your problems/Dealing with your feelings

> I was really hesitant, I was, I had never let anyone in and I had never trusted anyone. I'd learned not to trust people, you just don't trust people. They tell you to do something, you just do the opposite thing. But slowly I stepped just a little bit forward, and one step forward, and two steps back and just try. You know once in a while maybe I'd do a little step. . . at the end of the week I always used to look at myself and say "Do I feel any better than last week?", and every week I was feeling a bit better. So I started taking more steps forward.

* * *

> I started working in the program. . . At first it was harder, but I don't know it seemed to be working, I seemed to be feeling better, it seemed to be easier to talk, feeling better about myself. I knew more stuff about how to deal with my problems.

* * *

> What the program did do is it showed me that if I really try hard enough I can really find out what I'm all about, and I can really teach myself things about myself, and about other people and I can really communicate with other people when I really try. It taught me the most important communication skills about how to deal with your feelings and how to find your feelings because those were the things that I tried to hide the most from everybody because I didn't want to look incompetent or weak or out of control. So I was always hiding my feelings because I thought that is what feelings represented. So the program taught me

> how to accept the fact that I did have feelings, and how to encourage them to come out and encourage myself to share them with other people

* * *

> R: . . .Would you use those words or would you say different words to express that process of dealing with problems?
> Cl: Dealing with my feelings.
> R: Dealing with your feelings? That's how you'd phrase it?
> Cl: Ya.
> R: O.K.
> Cl: Dealing with the pain I would have.
> R: O.K. So would you use the word 'problems' at all or is that not. . .
> Cl: . . .well actually no, "problem" sounds like, well maybe I didn't have enough money that week to buy smokes or something like that. It doesn't. . . feelings or pain puts more emphasis on it. Sounds more better to me.

* * *

Using the group as support, adolescents can slowly begin to face both their problems, and the painful "truths" encapsulated by these problems. Doing this enables them to obtain more understanding about these problems. This step is entitled "Dealing with your Problems/Dealing with the Feelings" because at this stage adolescents often equate problems with painful feelings. It is these painful feelings, as much as it is the "root" problems, that adolescents are trying to deal with.

Coming to a turning point

> Because at that point you're completely wide open. I mean you've bared your soul and it's like when a dog rolls over and shows his neck to another dog. . . the dog shows him his belly and his neck and the dog can just kill him right there. You bare your soul and you

> are wide open for shots. I mean you bare your soul and that person or whoever, it could be anybody, and you don't want to do that really. I mean that's one of the toughest things in the world. You never want to leave yourself that wide open, but like the time when I, it was important enough with my father [. . .] to solve that or to change that it, because it was even more detrimental than. . ., the outcome would be more detrimental than baring my soul!

* * *

> There is a point in your life where you have to start loving and caring for yourself and your things, and when the kids here finally, when I finally found it, it was the best feeling of my life. . . .

* * *

Once adolescents have decided to start working, obtained the support of the group, and dealt with their problems and the feelings associated with these problems (at least to a degree), they reach a critical choice point in their work where the incremental gains achieved reach a kind of "critical mass." Adolescents must now decide whether to risk taking a crucial step. Taking this step requires hefty measures of both courage and desperation, but it also leads to new levels of understanding, thereby catalyzing the resolution of critical issues in an adolescent's life. In the first quotation above the adolescent describes this time as one of "baring his soul" as he sought to establish just where he stood in relation to his father.

Resolving problems

> There was never a time when they told you not to talk. You were always encouraged to talk and you were always encouraged to talk to the entire group so that nobody

was left out and everybody felt comfortable with each other, that there were no secrets and you could open up to each other and really help each other communicate because communication was the number one priority and it was done through talking. It wasn't done through smashing your head through a wall or vandalizing a car or doing anything like that. It was done through talking and it was very helpful because now since I've left [the program], I have rarely run into a situation where I can't really communicate with somebody, where I'm so stuck that I just can't do it. I can do it now because. . . I made that breakthrough where I discovered my weaknesses, discovered how to get to my feelings. . .

* * *

In the group you get a lot of different angles of it. People talk to you about it, ask you questions, and sometimes even act it out, and you get a thousand different angles on the situation.

* * *

I realized during group and on the floor that there was really no use for a temper and when it did come up, it would come up in big loads and there was no need for it. I just realized that I didn't need this and there was really no need for a big temper. There's always going to be a little bit of temper in me but not as much as I had. I still have a lot of that temper but I know how to control it now.

* * *

The kids, all of us, were together and we got into fights and learned how to resolve them and so that helped out in my own family because learning how to resolve them here taught me how to resolve them at home as well.

* * *

I took a lot of many steps and a lot of days dealing with it bit by bit each day, and every day I dealt with a bit and I'd feel a bit better. So it's kind of working through my problem day by day it got a bit better.

* * *

> I didn't have to rely on another person to make me feel happy. I didn't have to go out and see my friend to make me be happy. I could just be happy, I could just feel all around good, feeling healthier and not so black. . . .

* * *

> What's important? Being happy, but that's such. . . we've destroyed that word, "happy." We've completely abused it, and people don't pay attention to it, they don't give it significance any more. Being happy is the ultimate, that's the bottom line. . . I mean, just enjoying life, enjoying your company, feeling a sense of affiliation, like not being lonely. . . It's something you can't put your finger on, it really isn't, just enjoying life. Interacting with people has a lot to do with it, that's probably the most important factor is how, your relationships with other people. Not just like close people, I mean everybody.

* * *

Having summoned up their courage, and having taken the steps necessary to reach this stage of the process, adolescents see order and stability begin to replace chaos and unpredictability. By sharing themselves with others, by ventilating frightening, even forbidden thoughts and feelings, and by allowing themselves to lean on others for support, solutions begin to emerge. Sometimes these emerge as new skills, but more often they take the form of new insights - whether that be simple acceptance of an ongoing situation that isn't likely to change e.g., "I guess my mother really isn't going to take me home," or a new discovery about oneself e.g., "I never realized how much I bottled all my feelings up," or "Now I really know what being happy means."

Making progress

> And here proved that I am useful. . . with groups and that I can help others like they help me.

* * *

> Then you make level 3 and whatever, before you know it, you're eager and excited again.

* * *

> I was talking in group a lot and I was having more fun, I was having more fun with my friends. . . everything started looking pretty neat and I wasn't so lonely.

* * *

> It's your home and it's where you have to work hard. . . when you earn your outings and stuff it gets better, like when you're on level four or five with your off-complex. . .

* * *

> So I was always working because I really don't think, I never really let up. Once I got going on a roll [in the program] I never let up, it just got better and better.

* * *

By this time, adolescents can really see the light at the end of the proverbial tunnel. Successful adolescents begin to feel more empowered because they increasingly have a sense of accomplishment.

Taking a break from working

> You do other things besides work, you get to go on outings, you get to do a lot of different things here.

* * *

> One of the things was that you had to work your way up to get privileges to do activities and I think that really helped a lot; going to the pool and just having a good time. It wasn't all work. There was a lot of fun things that we got to do and that helped us relax and make it feel more like a family environment.

* * *

In passing it should be noted that the adolescents did not think that being in the program was all work. Being able to take a break from working, as in real life, was important for them. These times allowed opportunities for them to "play with" the staff. Having staff participate freely with them in activities was, as shall be discussed later, a crucial factor to them for determining whether staff really cared about them.

Completing The Work

> And I said, mmm, "But wait a second here there's something I haven't addressed here. . . and I'd say, "No I don't want to address it. . . what I've done is good enough, I can go with this and I can live with the rest. . ."

* * *

> That was really, really hard because you were so close, you felt yourself getting so close to graduating from C.A.S.E. and making all of these positive steps but you weren't quite there and that was working because you were thinking about that all of the time.

* * *

> No matter how awful you feel and how awful people treat you and how many enemies you have or whatever, as long as you deep down inside feel that you're a good person, you'll come out of it.

* * *

At some point in time, the adolescents begin to realize that they have actually resolved some critical issues in their life. Old problems no longer seem so overwhelming. Realizing that a difficult process not only can be survived but may even be near completion can be very empowering. Returning to live within the community now seems not only desirable, but feasible.

However this stage also has its stresses. Although there is a sense of accomplishment, there may also be a fear of failing so near to the end of the program. Struggling with conflicting feelings, and feeling that their work may be coming to an end, adolescents now begin to test their readiness to leave. Weekend passes become opportunities to assess whether significant changes have taken place. New adolescents coming into the program offer opportunities to compare "old" and "new" selves.

Feeling Ready to Leave

I really didn't want to stay, stay in another month.

* * *

> I was getting fed up with the program. . . I thought I did all the work I could do on my temper and my exposing myself and I, all I did in group is help the other kids and I really wasn't helping myself because I really didn't have anything to talk about or do. . . .

* * *

> People don't leave here until they are good and ready. You know if they don't want to leave they don't have to until they feel they're ready. . . . I knew I was ready, when I felt confident, I felt proud of myself, I was dealing with things, I was, I was happy, really happy. I still am, but you know I felt really good.

* * *

Feeling more confident about themselves and feeling increasingly restless within the program, adolescents now begin to signal that they do not want to work on their problems in the context of the RTC, but instead want the greater challenge and rewards of facing the problems in the "outside world." At this stage, it appears that the adolescent and staff begin to negotiate the feasibility of an adolescent's leaving by sending signals to each other about their respective perceptions of the adolescent's readiness to leave. This can be a confusing process.

* * *

> I kept saying "I want to go, I want to go, I want a discharge date", I was just, every time I'd see someone I'd say that "I want a discharge date."

* * *

One of the more common signals from adolescents at this time is a persistent agitation for a discharge date. However, because requesting a discharge date can also be a disguised request either for reassurance that they are not going to be discharged too soon, or for permission to be allowed to avoid important work, this signal has to be treated cautiously.

* * *

> When I first came I could of said "I want a discharge date, I want a discharge date," and I could of told you until you were blue in the face that I was ready to go and I didn't need to be here you know, and I wanted to go. Then I guess [in what I've] classified the middle part, you know I wanted to go, but I knew I was not ready to go, I knew I had, maybe I was only a quarter way or half way so I decided, you know I just started working a bit harder, maybe I'll get half way, then three fourths. I guess after a while when I let the group know everything about me, every single thing and told them how I felt about everything and I was a lot happier and I just felt like I knew how to deal with things. I don't know how to explain it. You just know when you're ready, completely ready. It's just something you know, truly you know it inside yourself when you. . . there are times when you probably say "I'm ready, I'm ready", but you're not ready, and you know inside you're not ready.

* * *

It is sometimes difficult to tell how adolescents determine their own readiness for discharge. When they were questioned, as the above quotation shows, they could not fully explain how they knew when they were ready. Thus, questions remain in this area. For example, do adolescents take their cues from internal sources like their feelings? Or do they rely on external facts like getting longer passes, or being on higher levels, or finding it easier to get along with the staff?

Although staff were not interviewed about this stage, one wonders how they form their opinions. Do they take their cues from their own comfort level with an adolescent? Do they look to external factors like the adolescent's ability to express him or herself more easily and appropriately. Or do they look to an adolescent's increased comfort level or his or her improved level of functioning as reflected by the level system? This is an area that merits more examination. At this time, it appears that both sides engage in an ongoing verbal and non-verbal "dialogue" in which observed facts are compared with desired goals to determine how congruently reality and desires match.

Getting a Discharge Date

> They said "You're out of here". . . .

* * *

> That was very scary when I found out I had a discharge date. I acted like I almost went back to square one when they told me I had a discharge date. . . .

* * *

> As soon as they get a discharge date it's like they freak out and they're scared again. . . .

* * *

> When I got the news of the discharge I was ecstatic, I was extremely, extremely happy, and it didn't hit me until a while after that I'm actually going to leave. I started getting a bit sad, to leave all my friends, all my favorite staff and leave. I was so used to the routine. . . I was so used to [the program] that it was kind of a shock thinking "Oh my God," you know, "Who's

> going to give me milk and cookies at three-thirty." You know I was really sad that I'd be leaving my friends. . .

* * *

However the decision is made, eventually adolescents do receive a discharge date. This is the official signal for them that it is time to bring some closure to the process. Soon they will be leaving, and it is now time to complete their work, at least for the residential phase of treatment.

As most adolescents go on to an out-patient program, they know that not all their work needs to be done in the program. However, they also know that it is expected that enough work will have been accomplished by the time they leave that they will be able to successfully stay in the community while they resolve either lingering or post-treatment adaptation problems.

Having tried so strenuously to get a discharge date earlier, adolescents frequently express joy and delight when they get their discharge date. However, often fear or sadness may quickly replace euphoria, as the reality of their situation sinks in – soon they won't have the program to rely upon. To allow adolescents enough time to work through their different feelings, the program usually provides a three to six-week period for this phase of the process.

Leaving

> I still had to deal with leaving, and goodbyes, and all of that, which you do get. Like that's why your discharge date isn't the next day. . . .

* * *

> I was kind of happy to get out and get back into the real world, but the only bad thing about it was that my parents weren't here.

* * *

There are three important steps in this stage: Saying goodbye, Leaving the problems behind, and Leaving the program behind.

Saying goodbye

> Part of me, you know, all of me wants to leave, but part of me just wants all of the kids to come with me, they can move in my house too (chuckle), because they're like my best friends.

* * *

> My last group really sticks out very well in my mind. I remember I said my goodbyes in that group, there was were lots of um, sadness but happiness, everybody was sad that you were leaving them but everybody was happy that you were moving on and getting along with your life.

* * *

For those adolescents whose presenting problems had to do with loss, e.g. the loss of a parent through death or divorce, this stage is particularly important. Often, the most important work these adolescents do in the program will be in this stage of the process. For other adolescents this stage offers an opportunity to experience a natural life event in a constructive manner. Too many of these adolescents have had people drift in or out of their lives with little or no opportunity to really say goodbye, let alone discuss how each person affected the other. The task in this stage is to deal with the painful feelings associated with having to disengage from what may be the closest group of which the adolescent has ever been a member. Not surprisingly, this phase is often the most painful for those who have done the most work.

Leaving the problems behind

> I can look at feelings and expressing my emotions with a different perspective [now]. . .

* * *

> Even though they are sad feelings I still find that I don't have to worry about them. They may bring back hurtful memories but they're all behind me now and I feel that I can talk about them and still know that they hurt and look around me and see that it has all changed now and I don't have to worry or be scared anymore.

* * *

If the adolescents have been working effectively, they now should have some sense of having been able to resolve their presenting problems. Furthermore, by putting them in perspective, adolescents should also be able to leave these problems behind. It's amusing to note how adolescents usually manage to leave some old clothes or belongings behind when they leave the program. Perhaps this symbolizes in a way how they are leaving their "old selves" or "old problems" behind.

Leaving the program behind

> When I went home they didn't have a schedule like they did [in the program] and that was one of my main fears when I left here. I was so scared that I wouldn't know what to do.

* * *

> . . .if I hadn't been ready to leave [the program] and I had come back to my old lifestyle, and hadn't been able to handle it the way I can, then I would of missed [the program] but I don't. . . that part is really over, [the program] is really over for me and I don't really want to go through it again and why should I. . .

* * *

If the adolescents have been working and if the program has truly been helpful, they will have avoided developing an unfulfilled dependent relationship with the program. Instead, they will have successfully joined with the others in the program to resolve those problems that were preventing them from accomplishing age-appropriate developmental tasks. Through hard work, they will have acquired new attitudes and skills that can be used in meeting the environmental and developmental challenges that lie ahead. If the program has truly been helpful and if the adolescents have really completed their work, they should be able to meet these challenges independently of the program.

Although some initial fears are quite common (as the first quote above shows), after facing some challenges, successful adolescents (as the second quotation shows) appear to be able to reassure themselves that they can deal with their problems in the community on their own. They no longer need the concentrated help of the program or to be further cloistered from the "real world." They have "done their work."

Summary

One way to summarize the information presented above is to use the six C's family of theoretical codes mentioned earlier. The six C's refers to six elements in a family of theoretical codes that all begin with the letter "C," namely: Causes, Consequences, Contexts, Conditions, Covariances, and Contingencies. Glaser (1978 p. 74) presents a diagram showing how these elements relate to each other. By adapting this diagram to the present study, it can be seen how this family of theoretical codes can summarize the data obtained in this study. Figure 3 illustrates how the BSPP of Doing Your Work can be summarized this way.

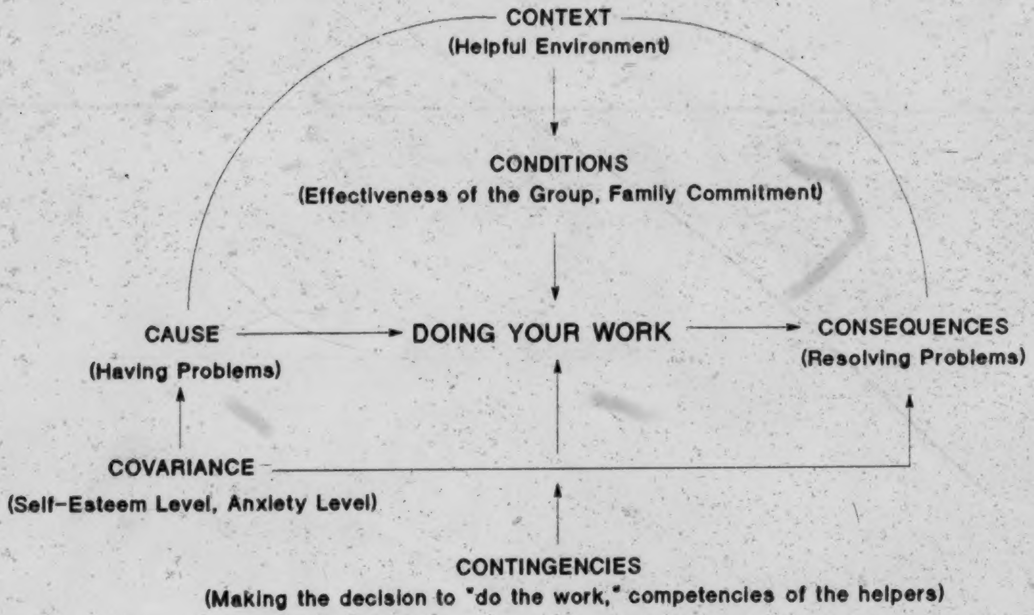

CONTEXT
(Helpful Environment)
CONDITIONS
(Effectiveness of the Group, Family Commitment)
CAUSE
(Having Problems)
DOING YOUR WORK
CONSEQUENCES
(Resolving Problems)
COVARIANCE
(Self-Esteem Level, Anxiety Level)
CONTINGENCIES
(Making the decision to "do the work," competencies of the helpers)

Figure 3. Summary of the BSPP "Doing Your Work" using the 6C's method

Briefly stated, the most parsimonious explanation of the **cause** or reason why adolescents need to engage in the BSPP of Doing Your Work is that they are being overwhelmed by problems. If they successfully complete the process of Doing Your Work, one of the **consequences** will be that their problems are resolved. The work adolescents need to do will be facilitated if it takes place in the **context** of a helpful environment (about which more will be said in the following chapter). More specifically, this work occurs in the context of the therapeutic milieu or the family environment. In the program this occurs either in the group rooms or in the living quarters of the unit (colloquially referred to as "on the floor"). In the family this occurs in the family therapy room and hopefully in the family home.

Glaser indicates that qualifiers is a synonym for **conditions**. Conditions that affect the process of Doing Your Work appear to be variables like how well the group as a whole is working, how helpful the group is perceived to be, and how committed an adolescent's family is to changing themselves. Variables that might **covary** in this process appear to be self-esteem levels (described by the adolescents as "feeling better" about oneself) or anxiety levels (described as "feeling more comfortable"). The ability of adolescents to engage in the BSPP appears to be **contingent** upon making the decision to "Do Your Work" and the ability of the helpers to be helpful towards the adolescents.

Throughout this chapter, the word "help" has been used a number of times. Despite efforts to avoid its usage, it has crept into the discussion. However, this just illustrates how both processes, working and helping, are present and necessary when adolescents are succeeding. The next chapter will look at the BSPP of Being Helped more closely.

CHAPTER FIVE

RESULTS and DISCUSSION: BEING HELPED

> In the long run I felt that it helped me out a lot and I don't think I'd be the person I am today if it wasn't for this place and I think it just helped me out a lot. It is a great place.

* * *

> It felt really good to get it off my back because I was scared for many years that that feeling would never go away and I think [the program] helped me. . . and I betcha it's helped a lot of other kids, I can tell by the way they are proceeding. . . . this is a good place for abused kids.

* * *

> The therapists and the staff members, they all helped a lot.

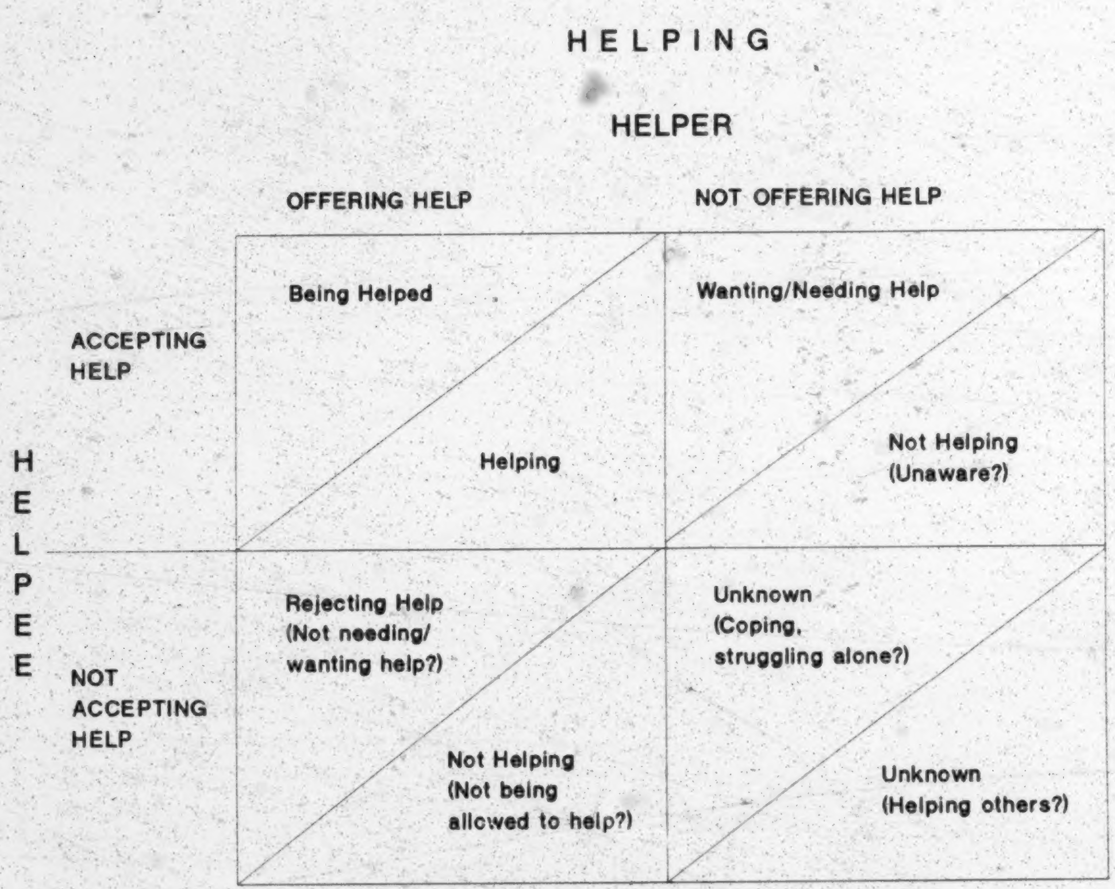
* * *

This chapter will follow the same format as chapter 4. First, the adolescents' use of the word "help" is discussed. Then the BSPP of "Being Helped" is examined. Statements from the adolescents that provide examples of stages in the process are presented, along with commentary by the writer. Finally, the BSPP is summarized using the six C's method.

Use of the word "help", and its derivatives (e.g. being helped, getting help), by the adolescents did not appear to be as complex as did use of the word "work." When adolescents used the word "help," it was usually as a noun e.g., "I got help," or as a verb. When used as a verb, it was used to refer either to the process of giving or providing what is necessary to aid or assist an adolescent to accomplish a task or satisfy a need, as in "The group helped me to express my feelings,"; or to the process of making a change for the better, e.g., "The program helped me with my temper."

As was the case with the word "work," use of the word "help" is clarified by contrasting it with one of its antonyms. If the program is "hindering" the adolescent, it is causing a delay or difficulty in the progress of the adolescent. It is not acting as a catalyst to growth, but as an obstacle or impediment.

The name "Being Helped" has been given to the core category associated with the theme of help because it seems to adequately encompass the different ways the process is referred to by the adolescents, and because it also emphasizes the interactive nature of this BSPP. While work connotes a process of "doing" something, help connotes processes not only of doing something but also of "exchanging" or "consuming" something. One assumes that if a process of "being helped" is occurring, help is being both offered and accepted. This implies that help is both available and being used. Therefore, even more than the BSPP of "Doing Your Work," the BSPP of "Being Helped" is an interactive process. Two or more parties - one of whom must be a helper and the other a helpee – must be involved. Both parties in the process have a role to play. Figure 4 illustrates some potential outcomes of different interactions between two parties.



	OFFERING HELP	NOT OFFERING HELP
ACCEPTING HELP	Being Helped Helping	Wanting/Needing Help Not Helping (Unaware?)
NOT ACCEPTING HELP	Rejecting Help (Not needing/ wanting help?) Not Helping (Not being allowed to help?)	Unknown (Coping, struggling alone?) Unknown (Helping others?)

*Upper left triangle in each square displays position of helpee.

Figure 4. A typology of the interaction between two parties involved in the process of helping.

Another way of illustrating the interactive nature of the BSPP of Being Helped is by examining its interaction with the BSPP of Doing Your Work. Figure 5 presents the results of different interactions between work and help in situations when one or both of the two BSPPs are either present or absent.

		WORK	
		DOING YOUR WORK	NOT DOING YOUR WORK
HELP	BEING HELPED	Resolving Problems Achieving Goals	Avoiding Your Work
	NOT BEING HELPED	Struggling Alone, Becoming Overwhelmed Becoming Alienated	Several Possibilities: Denying Your Problems, Avoiding Your Work, Taking a Break

Figure 5. A typology of the interaction between work and help

Being Helped: The Effects of Previous Experiences

> I guess I decided if I'm ever going to get out of here, you know maybe I should try what they say to do. Maybe, maybe something here works, maybe, you know I just, I wasn't saying I was going to do it, I was saying maybe I'll check out the possibility, check it out. You know I was really hesitant. I was. I had never let anyone in and I had never trusted anyone. I'd learned not to trust people, you just don't trust people. They tell you to do something, you just do the opposite thing.

* * *

For many of the adolescents entering the program the prospect of being helped appears frightening, even dangerous. For them, previous experiences with "being helped" have too often been unhelpful, either immediately or subsequently. Although some of the adolescents in the program have had very supportive parents, most of the others have experienced many negative "helping" experiences at the hands of their care-givers, often from an early age. Their requests for help, however communicated, often resulted in transactions of the quid pro quo variety, with a more powerful person deciding what was a "fair" exchange. Being vulnerable, the adolescent – then a child – had to sacrifice a fundamental human right – e.g., the right to be protected from sexual exploitation – to meet a basic survival need, such as the need for parental protection.

For other adolescents, early experiences involving requests for help are associated with either non-responsiveness or aggressiveness from significant others.

Their requests for help, admittedly awkwardly communicated at times, were met with silence or anger.

Thus, relationships for these adolescents came to be seen as exploitative, empty, or even dangerous, instead of nurturing. Feeling helpless as a child became associated with feeling weak and emotionally hungry, as others either took advantage of their situation to exploit, embarrass, or humiliate them, or did their best to ignore them.

Feeling helpless now, as an adolescent, therefore provokes much anxiety. Requesting help directly seems impossible. To deal with this anxiety, many adolescents adopt a stance of pseudo-maturity. Identifying with their aggressors they attempt (often quite successfully) to look "tougher" and act "smarter" than they really feel or are, trying to convince themselves and others that they "don't need help from anyone." Being unable to ask for help directly or to even consciously think about needing help, they may become overwhelmed by problems and develop symptoms indicating their distress and their inability to ask for help directly. These symptoms become the initial signals that they need help.

Therefore, to move from a condition of not being helped to a condition of being helped is an extremely difficult transition for these adolescents. For many, just learning to accept help is an essential aspect of the work they will need to do in order to succeed in the program. Thus one can see the reciprocal nature of the relationship between work and help. Adolescents need to be helped in order to work, but they also need to work in order to be helped. Extricating themselves constructively from this potential "catch-22" is a challenge for both adolescents and staff.

It appears that the adolescents who accomplish this task successfully go through a number of phases and stages as they move from a condition of indirectly signalling their need for help to a condition of no longer needing help. To better clarify this transition, the condition of not being helped will be briefly examined first.

Not Being Helped

Based on information gathered from the adolescents, there seem to be three primary situations that result in adolescents thinking that they are not being helped. These are: not being able to ask for help directly, not being adequately helped, and not wanting the help being offered.

Not Being Able to Ask for Help Directly

> I told them that scenario, "I can't go on like this." and my [grandmother] said "Why didn't you go inside and tell your parents this and ask them for help?" and I just went "The thought never even crossed my mind."

* * *

Far too often, unfortunately, adolescents are unable to be helped simply because they have either been unable to ask for help or been unable to articulate the kind of help they need.

Not Being Adequately Helped

> . . .so to get rid of these scared feelings I would go out with friends that I shouldn't have been with and I started doing drugs because they didn't make me scared anymore but that wasn't true. I mean after I found out what drugs did I was scared about drugs and so then I went to alcohol and then I found out alcohol is bad and I was scared about that but I still did everything and it just got worse and worse until I just didn't know what to do anymore.

* * *

> . . .at [another program] they were a lot more non-professional, immature, more personal, open up more, a different kind of person, they were only there to supervise really. . . .
> . . .they really didn't know what they were talking about. . . .

* * *

Typically, adolescents in this program have previously tried a number of approaches to obtain help with their problems. Whether based on their own ideas or those of peers or adults, their initial attempts usually proved to be naive, superficial, or even destructive. Later on, despite more sophisticated understandings or valiant efforts, they were not able to obtain adequate help to resolve their problems because their helpers lacked enough of the resources necessary to help very disturbed adolescents.

Rejecting Help

> I tried to manipulate everybody, to convince them that I didn't want to go because I had heard rumors that it was a place for bad kids to go, kids that had different

> kinds of problems than me, like legal problems not so much emotional problems. It just didn't seem like I would fit in and I felt it was unnecessary. I felt that I was being treated like a child or like a prisoner and that it just wasn't necessary. I tried to tell everybody, I tried to convince everybody that wanted me to go, that I didn't have to go. I did not want to go at all. . . it was the last place on earth I wanted to go, just because what I had heard about it.

* * *

Frequently, adolescents come into the program appearing not to want help from anyone. They claim not to have wanted it before they came to the program and adamantly assert that they do not want it now. Therefore during the first part of their stay in the program they usually reject help very determinedly. Depending on the adolescent, this stage may last anywhere from days to months. The challenge to the therapeutic working group (the staff and the pro-social adolescents – hereafter called the therapeutic group) at this stage is to signal the adolescent that "real" help is available. Unfortunately, for some adolescents, no one is able to help them to move beyond this stage, and they leave the program without ever feeling helped, often unaware of how they have been rejecting all attempts by others to help them.

Being Helped

> I think initially the main purpose is to show them that, is to make them feel that they have been put in an environment that is stable, and that cares for them and that wants to help them and I think that's the kind of environment that [the program] provides.

* * *

> They helped show that it wasn't all my fault and that my being here wasn't my fault and that there were problems that I could work out and they helped me work them out.

* * *

> . . . besides taking care of us, like making sure we had food on the table, blah, blah, blah, all that stuff. They . . . you know, they were also here to make sure that we had our feelings out on the table and that. They tried to help us talk.

* * *

Based on the perceptions of the adolescents, it would appear that there are three main phases in the BSPP of Being Helped that successful adolescents go through. It would also appear that successful adolescents perceive that the members of the therapeutic group best offer help by engaging in three corresponding and ongoing sets of behaviors or sub-processes in a larger process (Helping). These sets of behaviors provide, if effective, the most useful kind of help needed by the adolescent at each phase of the BSPP. Figure 6 presents the three phases in the BSPP of Being Helped. To aid understanding of how the BSPP of Being Helped interacts with the BSPP of Doing Your Work, the corresponding phases in the BSPP of Doing Your Work are also presented in this figure. Although these processes are conceptualized as "entwined," (e.g., like a braided rope or the DNA/RNA molecules mentioned earlier), for ease in

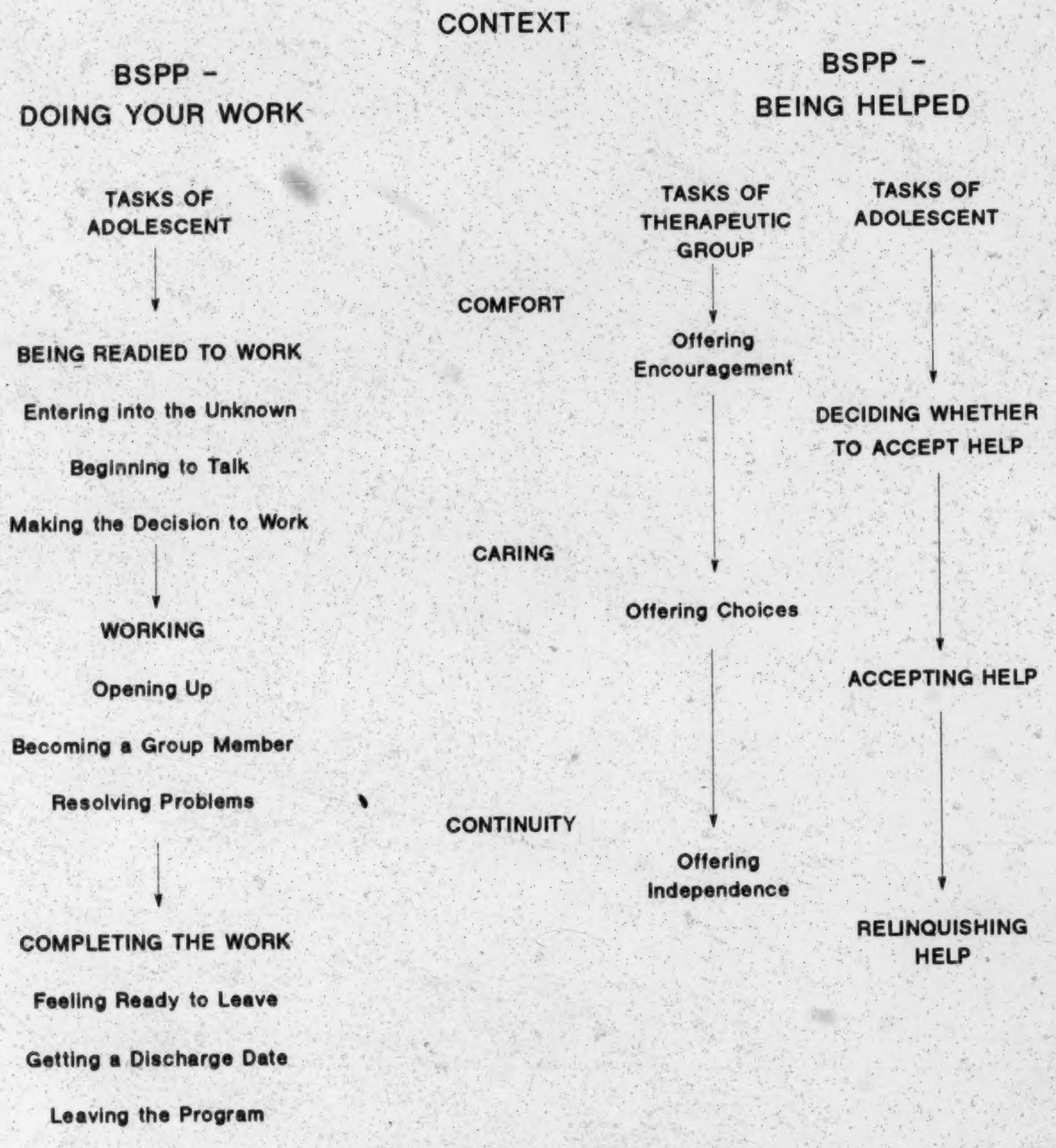

CONTEXT
BSPP -
DOING YOUR WORK
TASKS OF
ADOLESCENT
BEING READIED TO WORK
Entering into the Unknown
Beginning to Talk
Making the Decision to Work
WORKING
Opening Up
Becoming a Group Member
Resolving Problems
COMPLETING THE WORK
Feeling Ready to Leave
Getting a Discharge Date
Leaving the Program
COMFORT
CARING
CONTINUITY
BSPP -
BEING HELPED
TASKS OF
THERAPEUTIC
GROUP
Offering
Encouragement
Offering Choices
Offering
Independence
TASKS OF
ADOLESCENT
DECIDING WHETHER
TO ACCEPT HELP
ACCEPTING HELP
RELINQUISHING
HELP

Figure 6. Stages and tasks in the BSPPs "Doing Your Work" & "Being Helped," "unravelled," "straightened," and presented in parallel form for ease in presentation.

presentation, they are "unravelled," "straightened," and displayed in parallel form.

As can be seen in Figure 6, the phases the adolescents go through, together with the corresponding phases initiated by the therapeutic group, are: (a) Deciding Whether to Accept Help, which is triggered by the perception that others are Offering Encouragement in a context of Comfort; (b) Accepting Help, which begins with the perception that others are Offering Choices in a context of Caring; and (c) Relinquishing Help, which is most smoothly accomplished if adolescents perceive that others can accept moving into the position of acting as support and "back-up" for them while Offering Independence to them in a context of Continuity of Support.

The helping behaviors of the members of the therapeutic group, must, as a group, both be relatively constant in daily practice and be perceived by the adolescents to be relatively constant. That is, once each main set of helping behaviors is initiated, the adolescents need to perceive this help as being reliably available. This enables the adolescents to believe (trust) that help _is_ there and that other people are "being there" for them, as they progress through the stages of "Doing Your Work."

While any one set of helping behaviors may assume more prominence at a particular time, each set is potentially present from the moment they begin treatment. For example, adolescents will be offered choices in the beginning, but it is unlikely they will be able to make major decisions until they feel comfortable enough and encouraged enough by the group to take risks. Thus while the offer of choices is important, it assumes a lower priority at this time. However it must exist, and it must be perceived to exist by the adolescents as a possibility that can assume greater importance in time to come.

In this way, each set of helping behaviors becomes necessary background to the one that is foreground. Also, each set of behaviors builds upon and enhances the other sets. If an adolescent has a base of comfort from which to proceed, it will be easier to help him or her feel cared about. Similarly, if an adolescent feels cared about or feels that choices are available, he or she will feel more encouraged and comfortable.

Together these sets of helping behaviors provide adolescents with the ongoing perception that they are being helped. If one or more of these sets is absent or not present at the right time, or is perceived by an adolescent to be unavailable, that adolescent is at risk and is likely to feel that he or she is not being adequately helped at the particular phase he or she is in. In the next section, each of the phases successful adolescents go through will be examined, along with the actions of those helping them to move through these phases.

Deciding Whether To Accept Help

> At first I was, I didn't know what support meant. . . .

* * *

> . . . so it [being locked-up] got me really upset and I used to think "Well I must have done something really wrong if I'm going to be in lockup." I thought it was my fault that I was here and it really wasn't. I was just here to get help, not to be tormented by anyone, but sometimes I felt like that I was getting picked on by the staff. Then later on like before, ya a little bit later on they were being helpful, and I noticed that they cared for me and all I had to do was ask for a little help instead of trying to push them away all of the time.

* * *

> [Talking about what enabled him to stop rebelling against the program and start to accept it] . . . what's different, what's different from this stage to that stage? Maybe it was the fact that I got comfortable with the place, I got to know the people, got to know the staff, got to know the kids, the whole concept, the routine, maybe that had a lot to do with it.

* * *

When adolescents are at the beginning of this phase, they are usually unable to ask for help directly. Furthermore, their responses to stress, as was noted earlier, are often quite primitive. They can literally resort to the flight or fight response spoken of by Bion (1959). The challenge to the staff and other adolescents, then, is how to communicate to a new and often very suspicious adolescent that the program can be of assistance.

Staff members meet this challenge by providing a context of comfort within which they and the adolescent's pro-social peers can offer encouragement. Although the staff do not want adolescents to become too comfortable (lest it become counter-productive vis-a-vis the therapeutic work), this concern does not usually appear to be a problem at this stage, because a new adolescent has more than enough reasons to be anxious. Consequently staff efforts are normally directed towards decreasing rather than raising anxiety. When adolescents are helped to become more comfortable, it is much easier for them to respond to the encouragement being offered by the therapeutic group and to decide to accept help.

Providing a Context of Comfort

> . . .having all of the helpful staff, and having. . ., you know all of these little things I just mentioned, having all of these things there to support you. It was a very comfortable atmosphere to try and deal with your feelings.

* * *

> . . .[the] plates are like the size of a platter. Like they stack it so high and you get so fat in here (chuckle), no exercise, but it's O.K. grub.

* * *

> I actually wore that teddy bear out, hugging him so much (chuckle). So I got a new one before I left, but um, like in quiet time, or when you're sent to the time-out room, or something, you know he's somebody to talk to, you know you can hit him and stuff like that, and he won't say "ouch."

* * *

> You were always encouraged to talk and you were always encouraged to talk to the entire group so that nobody was left out and everybody felt comfortable with each other. . . .

* * *

Although the program attempts to provide structures and processes which enable adolescents to attain a degree of comfort by ensuring that their needs are met, the staff are still faced with a paradox in this phase. On the one hand adolescents are provided with objects or structures designed to help meet those needs described by Maslow (1954) at the base of his pyramid, i.e., the physiological needs, and safety and security needs. On the other hand, by virtue of being in the program and being deprived of their familiar attachments (Bowlby, 1978), it often seems to adolescents initially (and to naive "outsiders") that they are being deprived of these needs. Consequently adolescents often do not feel particularly safe or secure at first, especially just having been deprived of their familiar support system, and their freedom to make decisions or do the things they previously took for granted.

* * *

> They don't change the situation, they realized I was just coming in, what state of mind I'm probably in and at that stage there is no use in even attempting to bend the tree, it's not going to bend.

* * *

Therefore rather than attempting the impossible, adolescents at this stage are generally allowed to go slowly (or "go at your own pace" as they often say). The program does not ask much of them, but instead concentrates on offering those provisions necessary to meet their more basic needs, and in a manner designed to provide comfort. This is not a new idea in the care of disturbed youth (Bettelheim, 1974), but it merits some discussion.

Basic needs

> One thing that stood out really well (laughs) was the food because. . . the food was very well prepared, (it wasn't always good, sometimes it was gross), but there was always a lot of it. I always, I don't know if everybody else made this connection but I always connected that whole concept of. . . "there always something for you to eat here [to] there's always something for you to feed yourself to stay healthy", and I attributed that whole food health to group health, you know, thinking health. . . [I thought] that was the reason that there was so much food there.

* * *

From the time of admission, staff attempt to signal an adolescent that they are interested in his or her well-being. Being a quasi-hospital ward, the treatment unit has the advantage of being able to have medical staff attend to routine medical and physical complaints immediately. Therefore, if, for example, an adolescent is able to discuss an acne problem and then be placed on a treatment regimen on the day of admission, the adolescent has already accumulated some evidence that this program may be able to help with other problems.

When an adolescent is shown a clean, tidy bedroom with a teddy bear on the bed and is presented with fresh, clean pyjamas, the adolescent is covertly being given a message that "You're here to get well, and we're here to look after you." From the beginning, basic self-care issues like grooming and hygiene are emphasized. Although adolescents may argue or "fight" with staff over these issues, the unstated messages (e.g., We want you to look good and feel good) begin to affect their perceptions of both themselves and the program.

Shelter and food are also carefully attended to. The building was deliberately remodelled to suggest a "home-like" atmosphere which invites informality and relaxation. Food assumes a significant focus at this stage. Adolescents are encouraged to eat all they want. Initially adolescents may just see this as a chance to "fill up." However in a short while, they may begin to realize that there is more to this process of providing food than was apparent at first. They may begin to notice that the whole process is designed not only to help satisfy hunger, but to make them feel comfortable in the process. For example, instead of long dining-hall tables, they are seated at small round tables in groups of three or four, one of whom will be a staff member.

Later they will be involved in the preparation of the meals, thereby having a chance to participate in the process of providing a context of comfort.

As the effects of having these basic needs met begin to take hold, the adolescents begin to feel more comfortable. Now other needs can be addressed.

Safety and security needs

> You're really secluded and isolated and nobody knew about anything in there, not even people walking down the street they didn't know anything that went there, it's so secretive. . . and that was good! . . .it felt like jail, but actually it wasn't really a punishment, it was more like help.

* * *

> The environment, and the control you guys have over the environment. When I was here, when kids were here, and you would say stuff like, no visitors, or, only so and so, or whatever, right, or no mail, no phone calls. Very, very important, because you're dealing with a kid who has, you're trying to reshape his whole attitude, your trying to bend a tree another way, you can't have forces outside of here that are conflicting, which 99.9 like 100% are all conflicting to what you teach in here. . . you have to have total control. . . what I'm saying is the kid has to realize who's in charge. It's like training a dog kind of thing, once the dog knows who's boss. If the dog says "I'm the boss" you're in trouble. . . .

* * *

> You know it's pretty hard at first, you have to get used to it because you think "I'm never going to get out of here, there's no way, I'll be in here for the rest of my life," that's how safe they make you feel,. . . you couldn't really hurt yourself at all. . .

* * *

> There was a sheet on the bulletin board and if you didn't know where to go it would tell you exactly where to go and I found that very good for me because before I came here nothing was stable in my life. . . I knew that if I was ever lost I could just look at the board and it would tell me what to do. . . .

* * *

> Um, time out rooms I didn't understand, now I do. Um, especially when you took your own, it was a method of learning self-control and disciplining yourself and understanding when your about to break open and get angry then you could go and do it on your own.

* * *

> R: So it helped keep you alive, it helped you talk about problems. . .
> Cl: . . .and it kept me safe. . .

* * *

> I was realizing that nothing unsafe was happening to me, so something safe must be happening (laughs), and something right must be cooking along. I was physically fine, I hadn't OD'ed, I hadn't hurt myself, I was learning how to deal with that, you know. I hadn't hurt myself in over two months, I hadn't even pulled out a hang nail, you know. Something safe must of been happening, something right must of been happening I guess.

* * *

Almost immediately, if not immediately, new adolescents learn that the staff are in charge of the program. The adolescents have a "say," but the staff have the final word. Learning basic rules of the unit, believing that these rules are for their benefit and discovering that others expect them to be followed is often very difficult at first. However as a new adolescent continually hears from other adolescents how these rules have created an atmosphere of safety for them, and as his or her own experiences accumulate, the adolescent eventually comes to feel that his or her safety and security needs are being addressed. Additionally, routines and schedules begin to provide stability and predictability to daily functioning. Learning about the level system offers some understanding of the expectations of the program.

* * *

> It was safer because I knew the people around me, all of the kids. I knew them as much as they knew me. I felt really comfortable and I trusted them a lot. Then I started talking about my problems and about my feelings. I don't know, I felt safer. That wall that I always put around me up to protect myself from getting hurt, it started falling down and I felt more safer as it fell down which kind of sounds stupid because the wall was up to protect me, and to make me feel safe. After a while it just made me feel more lonely, more scared and more hurt. And as I started taking it down I felt more safe.

* * *

> [The program] also taught me how to express them, like how to get rid of them, like if I'm angry, how to say that, like "Listen I'm mad at you", not just walk away and think to myself "Boy, am I ever mad".

* * *

Two of the most important ways that the adolescents really begin to feel safe and secure (if not the most important ways) are by watching and hearing other adolescents express suppressed feelings that they themselves have long felt, and by beginning to express such feelings themselves. Taken together, all of the elements discussed above help to create a more comfortable atmosphere for the adolescent. Within this context, the encouragement of the therapeutic group can then begin to assume real meaning.

Offering Encouragement

> In group you find a lot of support where others have the same sort of problems, that's where group helps. But if you're just talking yourself, it's just like you're unloading a bunch of stuff off your back. But in group you're unloading it off your back plus getting someone to help you, kind of pat you on the back, so that's what group was for me.

* * *

> The problems that you bring into [the program] are problems that most of us have carried around for quite sometime, I think. We were encouraged by the staff and by the other kids to bring them out into the open because not only would it help for us to hear ourselves talking and working through the problems but it would also help other people that have been in similar situations to deal with them. . . .

* * *

> The kids brought it out of you. They really encouraged you. . . .

* * *

The primary source of encouragement, initially, is from the people within the therapeutic group. Although family members may provide motivation (as when an adolescent says "I want to get out of here and go home") and encouragement later on, they cannot really provide encouragement at this stage because an adolescent's admission into a RTC is usually seen by his or her family as a sign of failure (Menses & Durrant, 1990).

There is a relationship between the therapeutic group's ability to offer encouragement and the adolescent's perception of the comfort available in the surrounding environment. When the group is "working," it will be able to counter those sources of discouragement – the adolescent him or herself and the counter-therapeutic group (always present to some degree). However, if staff do not ensure the context of comfort is being adequately maintained at this stage, the power of the therapeutic group to be encouraging is diminished, while the power of the counter-therapeutic group is augmented.

While all of the people in the therapeutic group contribute to the provision of a context of comfort, it is the staff who have the primary responsibility to monitor and maintain this context. It is only by continually attending to this context that the therapeutic group will be able to credibly offer enough encouragement to an adolescent. With this encouragement the adolescent will then be able to decrease his or her anxiety enough to make a solid commitment to accepting help.

To summarize, in this phase it appears that adolescents who are ultimately successful first "test the waters" and then begin to conclude that not only might there be work that they need to do, but that it will be best accomplished if they accept help as they confront their problems. These adolescents will be helped to come to this conclusion more readily if the staff and the other adolescents are able to offer encouragement within a context of comfort.

Accepting Help

> To me, when I was here, it was a family and they [the other adolescents] were my brothers and sisters and that's how I felt and you felt like you could talk to them.

* * *

> (Asked what she would say to a kid that was going to be coming into the program) Don't fight it. . . Accept the help, don't deny that you don't need it because you must need help if you're in here, and, like you know, let reality hit you, tell yourself that you do need help.

* * *

> You can accept the fact that people want to care for you, and let down your guard and allow it to happen, and allow yourself to experience that type of caring which a lot kids going into C.A.S.E. were not used to.

* * *

> . . .sometimes I felt like that I was getting picked on by the staff. Then later on like before, ya a little bit later on, they were being helpful, and I noticed that they cared for me. . . .

* * *

> If we sat down to play a game of foozball the [caring staff] would always be there playing with us. They would be sitting in the pit listening to music and sitting and talking, they would always be with us. If we were sitting playing crafts they'd always be sitting there talking to us about little things, chit-chat. . . .

* * *

> I feel that this program helped me talk about my feelings and get them out in the open and help me pin-

> point what I was mad at, why I was mad. They helped me pin-point why I was scared, the things I was scared of and they helped me build a new dream for myself, a realistic dream.

* * *

As can be seen from the above quotes, there is much that happens in this phase. It is during this phase that most of the "work" is accomplished. It is at this time that most of the help is needed. In one sense, one could speak of being helped in this phase by using phrases like "being helped to open up," "being helped to become a group member," or "being helped to work out your problems," and indeed the adolescents do speak this way. However by reading between the lines of what the adolescents are saying, and by attending to their occasional comments, it appears that the work adolescents need to do in this phase will be most easily accomplished if the essential nature of the help being provided involves helping them resolve conflict by offering them choices within a context of caring.

How does one offer these adolescents choices? One begins by providing them with a caring environment. As with the first phase, adolescents will be able to respond more easily and appropriately if they perceive that what is being offered is being offered in a helpful context, in this case a context of caring. Therefore, the context will be discussed first.

Providing a Context of Caring

> Even from the very beginning you can tell from that, like that's the feeling that you get, you try and fight it but that's the feeling you get, and that's what allows you to feel secure and open up, and I think that's the most important thing that the C.A.S.E. program tries to offer everybody, is that. . . the ideology that they care and that they want to help.

* * *

> They [staff] are there to take care of you too and give you the attention you need.

* * *

> These people [caring staff] were always really polite, always! They were, really nice and understanding and you could feel them, you could feel their caring. You could sense it. It's hard to explain, like if you walk past somebody you can kind of feel, if you walked into this room and it was full of a whole bunch of mad people you'd know, you could feel the tension but it's just like sensing that they care, you know.

* * *

> I thought the kids really cared, they you know, they said they'd been where I've been, they've gone through what I've gone and you know, they know what I'm feeling. First it was impossible, no one knows what I'm feeling, but after a while I realized that they did, you know, and I felt that the kids really cared, and they understood, and they were here to support me and help, but also help themselves.

* * *

To fully benefit from the choices being offered to them, it appears adolescents have to perceive that they are cared about. They have to perceive that they are valued enough that their well-being is of great concern to others.

* * *

> When I came in here I was mad at the world and they helped me find out more who I was mad at. They made me talk about my feelings.

* * *

If one realizes that it is the adolescent's over-all well-being that is important, one can understand that "caring" does not refer to some superficial, pseudo-polite kind of caring. While supportive or soothing responses are necessary, helpers who are truly empathic to the adolescent's needs will sometimes be very confronting in their caring behavior. They will "make" an adolescent talk about painful issues or feelings, rather than ignoring or allowing the adolescent to "act-out" the feelings. This shows the adolescents that the helpers care about their well-being, and will not tolerate self-damaging behavior. Confronting also sends a message to an adolescent that he or she is seen as a responsible person capable of making good choices.

* * *

> There was a lot of fun things that we got to do and that helped us relax and make it feel more like a family environment.

* * *

To provide a context which radiates messages of caring, the program attempts to simulate a family-like atmosphere, although the notion of an extended family would probably be more accurate. Even though the adolescents may talk about the program as if it was like being in a family at times, the program itself does not attempt to re-create the nuclear family. This would not only put some adolescents in a loyalty bind vis-a-vis their existing family, but might also make the "work" of mourning family losses more difficult. Thus, when the therapeutic group functions like aunts, uncles and cousins, the adolescents are able to be close to others without provoking primal loyalties. However, they are still able to transform the therapeutic group into a family if that is what they need to do.

Offering Choices

> They helped show that it wasn't all my fault and that my being here wasn't my fault and that there were problems that I could work out and they helped me work them out.

* * *

> I know a new way to deal with things, a new way to live, a way to live happy. You know I'm sure there's going to be rough times and everything, it's not going to be happy forever, but I'll just deal with them when they come.The program helped me to realize that, helped me, it kind of gave me a solution. Well I found it, but they put it in my path.

* * *

> . . . they help you find and realize your problems and then they give you the tools to work out your problems . . . They just give you the tools, they help you realize what your problems are, and how to recognize a problem, and then you deal with it.

* * *

> . . . they taught you how to help yourself. Like I was saying they helped you and poked you all along all of the time but definitely in group they teach you how to

> help yourself. Help yourself emotionally and then in life skills help yourself and take care of your, your belongings and your, your rights physically. So they help learn, they teach you how to help yourself two ways.

* * *

> . . .it taught me a lot about myself and about the weaknesses that I had and that I had a hard time admitting what my weaknesses were and it taught me how to communicate better with my family and with my friends, and even how to communicate better with myself, and how to understand my needs more. So I would say that it was a learning experience. . . .

* * *

> . . .so I chose, you backed me up and that gave them reassurance and . . .whatever. . ., displayed importance of the program or my, no. . . your respect for me. . . .

* * *

A gangly adolescent sits cross-legged on a pillow in front of the nursing station. Shoulders slumped, head down, he sits quietly, barely moving, until a timer goes off indicating his five-minute "pillow" for "not listening" is over. Before getting up he is asked why he got the pillow. When he is then asked how he might handle the situation next time, head still down, he spontaneously replies "Make better choices." He then looks up towards a much shorter, female staff member. Making eye contact, they both smile knowingly. He then gets up, turns and walks down the hallway towards the other kids (Field note, May 1, 1991).

Why didn't this obviously much bigger adolescent (with a history of violence) just get up and hit his staff? At one time he would have. Why would he even allow himself to sit on a pillow in full view of anyone who walked by the nursing station? At one time it would have taken two strong men to just to put him into a time-out room. Part of the answer is that he now knows he put himself into his predicament in the first place. He knows there were better choices he could have made about how to deal with upsetting feelings. He also knows that he can still make matters better or worse, the choice is up to him. So why didn't he make the better choice earlier? Will he make the better choice tomorrow? Wouldn't it be nice if progress was measured in nice straight lines.

This incident emphasizes the importance of helping adolescents learn how to resolve problems by helping them to learn that they do have choices. Adolescents will learn this concept much quicker, naturally enough, if they are offered choices. Although the quotations at the beginning of this section do refer to learning new techniques, or acquiring new skills, they especially emphasize being helped to learn about oneself and being taught how to help oneself. This is primarily what is meant by being offered choices.

* * *

> [Before the program] I had a lot of pain, and I didn't know how to deal with it. . . . Not once did it ever

> occur to me that all these feelings could just be talked about, and dealt with and you know, that it would take quite a while, but if I dealt with the feelings that would happen, that would take away some of the pain.

* * *

Being offered choices does not just refer to preselected choices that the staff or others provide, although this may be part of the process, especially in the beginning. Instead it refers to the goal of increasing the options available to the adolescent. The adolescents' options will be increased if they know more about themselves and if they learn better ways to help themselves. Thus if the therapeutic group is helping to increase options by helping adolescents learn about themselves and learn how to help themselves, it is increasing the choices available to them. In turn, the adolescents then have to assume the responsibility for making choices. Struggling to learn how to make good choices is part of the work for the adolescents. Increasing options by offering choices to them is part of the help that must be provided.

It is assumed that if adolescents have more choices available to them and if they are engaged within a context of caring, then not only will they try to make choices beneficial to themselves, but they will also eventually try to make choices that benefit the group providing the caring as well. At first this group most likely will be the therapeutic group. Ideally, choices that benefit the adolescents and the therapeutic group will eventually benefit the other significant groups in their lives - e.g., their real or surrogate families.

A paradox of a caring environment for adolescents is that it allows them to reject caring - up to a point. This reveals another paradox, which is that a caring environment offers choices, but within limits. Thus the program will allow adolescents to reject help from others, e.g. allow them to withdraw from others, or "do it their own way," but will not allow them to injure themselves or others. The message to an adolescent here is "We accept the fact that you have angry feelings. However, we will limit your choices on what you can do with your feelings until we can help you find better choices about how to deal with those feelings."

After being provided with a caring environment, adolescents have to be offered additional choices. This is best done through the medium of the therapeutic group initially, and then increasingly through the family therapy sessions later (if family members are available).

The Therapeutic Group

* * *

I guess every group is a different family.

* * *

> In the group you get a lot of different angles on it. People talk to you about it, ask you questions, and sometimes even act it out, and you get a thousand different angles on the situation.

* * *

> I guess after a while when I let the group know everything about me, every single thing and told them how I felt about everything and I was a lot happier and I just felt like I knew how to deal with things.

* * *

If one were to take an ecological approach (Lewis, 1988), the therapeutic group might comprise the entire body of people surrounding an adolescent who are attempting to help him or her. This would, for example, include social workers, probation officers, and family members. In the program though, adolescents perceive the therapeutic group to consist of all the staff and adolescents within the therapeutic milieu engaged in helping an adolescent. These will be the people they are referring to when they are quoted saying "The group helped me."

While parents are also seen, understandably, as very significant, the adolescents place them in a separate category of their own. Other helpers (e.g., social workers) are generally seen as operating outside the therapeutic group.

Adolescents categorize sources of help within the therapeutic group in two ways: by the name of the formal group they're referring to, e.g., "large group" or psychodrama group; or by the name of the subgroup of people they're talking about e.g., the kids, the staff, or the therapists.

Formal groups

> Large group I think is the thing that stands out most because we did that quite a lot. It helped me. Large group was really good because we got to listen to the other kids problems as well as talked about our own problems and we got to help the other children as well as they got to help us and it seemed like it was very important that the kids could intervene with that because some times we were so mad at the therapists that we didn't want to talk to them.

* * *

> Large group was probably the most helpful, in the large group you found out about everything. What everybody was feeling. . . .

* * *

> The large group is probably a very important one. It was very useful because you were interacting with the most people and all the therapists I guess. That's where you work out the most of your problems, and that's the official group. The significance has a lot to do with it, like the official, it being the official group. Like I would, I know lots of kids, uh, well it's beneficial and there's negative and positive effects of the group being "official." Being "official" that's where you really express your feelings. If some kid was going to apologize, or say something about. . . blah, blah, blah, and wanted to show he was working so he'd get away that weekend, he wouldn't talk about it in goal-setting. He talks about it in large group. I did that.

* * *

> They'd be afraid to bring up information in large group because of the. . ., I don't know. . ., just because of the numbers, they'd feel safer in a small group.

* * *

> Of the [groups], I think all of them help out in a very, . . .the sum is greater than it's part, no, no, the sum is greater than it's parts, absolutely. . . . so the whole, like I said, the concept of all of them together is very important. . . .

* * *

Keeping in mind that all of the formal groups are just different manifestations of the therapeutic group and that the whole is indeed greater than the sum of the parts, it is probably fair to say that of the formal groups the primary therapy group called "large group" is the most visible and important manifestation of the therapeutic group. This group, which meets daily, consists of the program psychiatrist, all the adolescent patients, the therapists, and other staff members on a rotating basis. In the eyes of the adolescents, not only is this where they do most of their work, this is clearly where they see themselves being helped the most.

The other formal groups with a therapeutic mandate include the remedial education program (school), the psychodrama group, and the other groups known as the "small groups." These latter groups teach skills, (e.g. communication skills, life skills) and offer opportunities (e.g. through projectives, movement therapy) to express feelings in less verbal ways, or to help surface or catalyze feelings that can then more safely be brought into the large group.

People in the program

> I don't know how you guys choose your staff but you do a very good job of it. They're all really great people and they all have an integral part in developing the students or helping the patients' relationships. In turn the other kids do too, the other kids help. . . who helps the most. . . a toughie. . . .

* * *

> I feel like it was the staff that really brought a lot out of me, the staff really helped me a lot.

* * *

> The kids are nice, the kids helped me out a lot.

* * *

> I'd have to say that the key worker and your primary therapist are two of the main teachers along with your parents.

* * *

> . . .it seemed like it was very important that the kids could intervene with that because some times we were so mad at the therapists that we didn't want to talk to them. We didn't care about them. We thought they were in it for the money and when the kids got to talk to us we felt we were on the same level.

* * *

> A lot of [the kids] when you first come they act so tough but in group they're just pussycats. You know they cry, and you know they talk, and they really do care. . . so that really helped me a lot.

* * *

Typically, one often thinks of troubled adolescents as being ruled, or at least heavily influenced, by their peers. However while acknowledging the importance of their peers, the adolescents interviewed in this study strongly emphasized that the staff also assumed a very important helping role. This suggests that the role of adults vis-a-vis adolescents is more important than is often assumed.

Program psychiatrist

> R: O.K. Tell me what else you remember about the program.
> Cl: Um, Dr. B.
> R: O.K. what do you remember about Dr. B.?
> Cl: Um, his cigars (chuckle).
> R: Anything else. . . or?
> Cl: . . .just the way he used to talk to me, you know, made me feel like I should be here, and I belonged here, and he convinced me that, to stay and stuff.

* * *

> I remember [him] coming and seeing me and saying "I have a place on this complex, do you want to stay there?"

* * *

> So that first month I really had to try and adapt to the fact that he wasn't agreeing with anything I was saying and he thought I was "full of it". He pushed me really hard by really just sort of turning away from me, and that made me angry and it made lots of feelings come out. So in a twisted unhappy sort of way it helped. . . .

* * *

> I don't think Dr. B. came third but somewhere in there he would come, because he's like god, he's like this invisible force, like his unit he's in charge but he's not directly involved in the entire therapy. I mean the primary therapist is doing the majority of the work but Dr. B. is there to make sure you're not sidetracking yourself or to make sure that overall, it's going the right way and maybe he can change this or that. He just sets the ground rules I guess, because it's his theory, his whole concepts.

* * *

> I think it would be better for the kids there if [he] was there more often in large group. I remember being really angry that he was only there, like only once/twice a week and he never really caught on, he got all the information from the therapists but if he was there I'm sure he'd be able to understand the children better and understand how they feel and actually watch the progress in the program.

* * *

> You can't see Dr. B. one to one, that's kind of bad but other than that it's a pretty good program.

* * *

It is not known for certain whether an adolescent program needs a strong, inspiring leader to be effective. Certainly the early treatment programs for children and adolescents that were written about were usually led by persons that inspired their patients to be more than they thought they could be (Aichorn, 1934; Bettelheim, 1974; Redl, 1954). However, it's a rather moot point in this program, because there's no doubt that the program psychiatrist, affectionately known as Dr. B., evokes strong and passionate feelings from his patients. Undoubtedly some, or even many, of these feelings are transference feelings, but clearly not all are. Talking to these adolescents one senses deep feelings of admiration and respect that carry on long after they have graduated from the program. Often he is the first person in the program they meet and the last person they say goodbye to. In this way, he acts as a bridge both into and out of the program.

Clearly, he is seen as a special source of help. How much of this is by the nature of his person or his position would require further investigation, but one gets the impression that while other individuals in the program are more or less replaceable, this is not as true for him.

There is some indication from the transcripts of this study that successful adolescents are more able to "let go" of him as they leave the program, whereas less successful adolescents still remain somewhat "attached." However, it is difficult to generalize with such a small sample; therefore this remains an intriguing question that invites further exploration.

Family Involvement

> [The family therapy sessions] were very successful and productive because my parents were so motivated. . . to come. My dad said to me, ". . .the 100 yards walking from the car to here was one of the toughest 100 yards I've walked in my life."

* * *

> We had a lot of family groups, once a week I think it was, and I found that helped a lot but in my case my mother [travelled out of town] and I was very angry at her because she didn't come to all the family groups that she should have come to and she didn't come to all the visits that I wanted her to so I was still angry at her when I came back home so I think we should have talked more about my mother not being home because that's one of the reasons why I was in a mess to begin with.

* * *

> There is very much, parents take you under their wing again. I very much feel that. I remember one of my first, I think it was my first trip away, my first weekend pass, I went home, cleaned up the garage and

> all that. I remember I went for a walk with my parents, and it just seemed like they were my parents again and I was the child again. It was more their protection, and their faith that really helps. . . .

* * *

> I hated them [family therapy sessions], I really did because uh, mmm ah my mom and step father had to come and I just, I didn't really like it that much because there was a lot of yelling and stuff.

* * *

> I wouldn't of been able to do this without my mom because she cared for me more than she ever had before. She cared a great deal and it felt so good. . . .

* * *

Families, particularly parents, occupy a unique role in the program, because they are both inside and outside of it. As expected, their role is critical. Unfortunately, this can be as much for the worse as for the better. Much of the work adolescents do in the program is in relation to their family. The main arena for this is in the family therapy sessions (also called family meetings, family groups, family interviews, the particular name is chosen by the adolescents and seems reflective of their family's acceptance of therapy). When families are involved in the program, few adolescents seem able to succeed if their family does not support their attempts to change by making reciprocal changes themselves. If the family is able to readjust to support the adolescent by offering him or her new alternatives, then he or she can make dramatic recoveries at times. However, if the family is not willing to adjust to help meet the adolescent's unmet or newly evolving needs, the adolescent's choices become severely limited.

Of those adolescents interviewed who succeeded despite having a family who did not change, it seemed that they did this by developing a form of compensation. They coped with the loss of their family by eventually replacing it with an ongoing substitute outside of the program. Of three adolescents interviewed who were in this situation, two had successfully "created" surrogate families. The other adolescent was still in limbo. He was staying in a good group home but was anticipating reuniting with his family in the near future. Although this adolescent was doing quite well at the time of his interview, one wonders how he will fare if his latest attempt to enlist his family's support fails.

Making Choices Visible

> [Asked what the main purpose of group was] Just to talk about problems that you have in common, and to help each other, and learn skills of listening and, and reflecting upon yourself and upon others. In group you find a lot of support where others have the same sort of problems, that's where group helps.

* * *

> I didn't know what my feelings were, I didn't know how to grab them but after about a month or two I started talking a lot and trying to understand why I had to talk and how important it is for me to know my own feelings so I can proceed in life and not have them

> dragging around with me wherever I go. This place is successful for getting all of your, um, feelings sorted out. It sure helped me.

* * *

> The problems that you bring into [the program] are problems that most of us have carried around for quite sometime, I think. We were encouraged by the staff and by the other kids to bring them out into the open because not only would it help for us to hear ourselves talking and working through the problems but it would also help other people that have been in similar situations to deal with them because together by talking and sharing it was a lot easier to communicate because you didn't feel like you were all alone in the world and your problems were so hard to deal with and so deep and so. . . just frustrating that there was nothing that you could do about them. Hearing somebody else being able to relate to your problem made it a lot easier to deal with.

* * *

Although the adolescents do not talk about being helped to see new choices directly in the above quotations, or even being offered choices, this seems to be essentially what is happening here. By having encouragement and support to talk about their troubling thoughts and feelings, they are eventually able to "sort out their feelings" and move from a state of confusion to one of greater clarity. Listening to other adolescents share their problems helps them put theirs into perspective. Hearing about other adolescents' struggles and attempted solutions also serves to act as a kind of "brainstorming session," thereby increasing the choices available to them in their own situation. As these choices become more "visible" to them, and as they take risks and make choices, they eventually discover solutions that work and their problems begin to be resolved. This in turn helps them gain more experience and skills in solving problems and resolving conflicts. Success builds upon success and their confidence and self-esteem levels begin to increase. Their repertoire of skills also increases, thereby improving their chances of making good choices in future situations.

As the adolescents continue to see new choices, resolve problems, and gain confidence in their abilities, their desire to resolve more of their own problems grows stronger. As this happens, they begin to relinquish help.

Relinquishing Help

> [Going out on passes and activities] was really, really hard because you were so close, you felt yourself getting so close to graduating from [the program] and making all of these positive steps but you weren't quite there and that was working because you were thinking about that all of the time. So while all of those little evenings and adventures were enjoyable it was still work because you were still thinking.
> R: O.K. It sounds like in some ways they were enjoyable but they were even harder in some ways.
> Cl: Ya, exactly and it required a lot of discipline because, I mean you were given a lot of freedom, and a lot of responsibility, and you really had to decide where your priorities were and that finishing C.A.S.E. was the best thing to do.

* * *

> That was very scary when I found out I had a discharge date. I acted like I almost went back to square one when they told me I had a discharge date. . .

* * *

> I came here and I got some benefits, I got a great deal out of this place, I really did. And I said, mmm, "But wait a second here there's something I haven't addressed here. . . and I'd say, "No I don't want to address it. . . what I've done is good enough, I can go with this and I can live with the rest. . ."

* * *

> All my feelings aren't gone yet. . . I still have a lot of them left, I just know how to deal with them, I know that if I cry it's O.K. and I can talk to people. . .

* * *

> Cl: . . . I was wishing that one of the foster parents were mine but then I left and I never got foster parents. I could of stayed another month and got some but I wanted to get out.
> R: Why were you wanting to leave?
> Cl: Uh, I was getting fed up with the program and, because I thought I did all the work I could do on my temper and my exposing myself and I, all I did in group is help the other kids and I really wasn't helping myself because I really didn't have anything to talk about or do.

* * *

In reviewing the first several transcripts, it appeared that while the adolescents spontaneously spoke of being helped by the program, there was little spontaneous discussion of how they made the transition from being in the program and being helped to not being in the program and not being helped (at least by the program). Consequently, little direct information was acquired from these adolescents on how they proceeded to relinquish the help of the program.

While it might be argued that the adolescents did not want to be discharged, and thus had no choice about giving up the help, in actuality the cues about readiness for discharge are usually taken from the adolescents themselves. Therefore, it is generally they who are sending the message that they no longer feel in need of help.

While it is not so clear how adolescents begin to relinquish the help of the program, it is clear that once they reach this phase, they usually become increasingly restless about staying longer in the program. If they have been working, they have accomplished much of the work they need to do. Most of their presenting problems have been resolved or ameliorated. They have been out on several passes with their family or foster-family. They have adequately managed both short passes of four hours or less, and longer passes of two or three days. They increasingly feel the pull of the outside world and want more involvement with it. They persistently begin to agitate for a discharge date.

As contrasted with adolescents who have been avoiding working out their problems, most successful adolescents do not want to leave to avoid more painful work. Rather they want to leave to get on with their lives now that their situation seems better. In order to do this, they have to relinquish the help being offered in the program. However, because the adolescents did not spontaneously describe specifically how they went about doing this, this process was first inferred from what they said. Later, further interviews where this question was asked specifically were undertaken to obtain a clearer understanding of what is involved in this phase.

When adolescents begin to relinquish the help of the program, it appears that despite wanting to let go of it, they often find that it's more difficult than they expected. Although they fought against it earlier, they have now come to appreciate being helped, and often feel ambivalent about giving it up. This ambivalence can be seen in the above quotation about receiving a discharge date. As mentioned earlier, getting a discharge date often results in mixed feelings. Initial euphoria about getting one's freedom back is often followed by fear and sadness about losing the support of the program. These feelings are often expressed in symbolic ways, e.g., a sudden regression to old unproductive ways of behaving, or expressing the wish that everyone could come with them when they leave.

Based on inferences made from adolescents' comments, it appears that relinquishing the help of the program and moving towards independence is easier to do if it can happen in a context of continuity of support. If adolescents perceive that they are being offered more independence along with assurance that elements of the program - namely comfort, caring, and help - will still be provided as they go forward to meet new challenges, there will be enough of a sense of ongoing support that they will be able to take the risks necessary to move forward. If they do not receive this assurance, they tend to regress, either just before or soon after leaving the program. Thus it would appear that the challenge at this phase for helpers is twofold. They must provide opportunities to acquire more independence and they must provide a context of continuity of support while the adolescents "test out their wings."

Providing a Context of Continuity of Support

> I think that they should prepare more for a discharge date because like I said that was very scary when I found out I had a discharge date. I acted like I almost went back to square one when they told me I had a discharge date, and that's one thing I think they should try and find a way to just prepare the kids more before they just sort of shout out they have a discharge date. Prepare them before they give them to them.

* * *

> I felt I should have been integrated on the outside a bit more before I just got discharged. Because when I got discharged I hadn't really been out in crowds and I felt like such an outcast. . . I feel that I should of had a bit more time, like coming back and forth, like say like for an hour for group or something. Because like it was really hard when I graduated and I had nobody to talk to after I graduated.

* * *

> The structure made me rely on people too much, made me rely on people to say where I'd go, what I'd do. Where in the real world the only structure I have is my scheduled classes and then it's me who makes me go to them or not go to them, or go to my appointments, or not go to my appointments.

* * *

> Now I just know I need structure otherwise I'm gonna screw up and I'm gonna screw up worse every time . . .this structure thing, quite a big thing I think. Cause lots of kids can't handle life if they aren't being told what to do. Some can but some can't. (Unsuccessful adolescent readmitted to hospital following a drug overdose)

* * *

> . . .most of the problems were solved but I don't think we looked at family problems enough like we should have. We more or less looked at my problems and I was free to leave and I feel that I left when I should have left but I don't think I should have gone to the family because the family as a group was not ready.

* * *

As indicated earlier, initial information about this need for ongoing support was obtained in an indirect way. Frequently the adolescents made comments about what they would have liked to have had happen as they were leaving the program. In reading the transcripts of both successful and unsuccessful adolescents, it becomes clear that providing a context of continuity of support has been an area of weakness within the program. Although current practice is to refer most adolescents to the Adolescent Day Program, where they continue on an out-patient basis, most adolescents still find the process of leaving the program very stressful. It appears that the program has not consistently been able to offer reassurance that the continuity will be there. This indicates that further work is still needed in this area.

It would also appear from the above quotations that it is wise to continue the current practice of tailoring discharge plans to the individual adolescent. While one adolescent may be ready for a much less structured home environment, another may need a tightly regulated environment which the family may or may not be able to provide. Ultimately, however, the adolescents need to develop their own structure. Those who succeed seem to realize that it is their responsibility to help create the rules that will provide them with a helpful environment. They realize the program has given them tools to help them accomplish this, but not recipes. They realize that they must develop their own formula for a healthy environment.

Offering Independence

> When you're on level 5 and 4 it's smooth sailing. Like you get to go out and do some activities with your friends and finally you're getting some of your freedom back because you've earned it. You have to earn your freedom here, you can't just get it by the snap of your fingers, you've got to talk in group, you've got to support, you've got to do the day program, you've got to make your bed in the morning, you have to do everything like that.

* * *

> You have tests, no, not tests, you have situations where you can apply these skills and there is room to screw up, like a day pass. You're allowed to go out for wherever for a day. . . .

* * *

> There's the weekend pass, I mean two days you can't do anything. You just cut loose and your dad says "Hey let's go here", so you have a little time with your

> father or a little time with your family. Two days you don't learn a lot and for me two days or four-day weekend was really not enough.

* * *

> I knew I wasn't ready when I got discharged, but I wasn't about to admit [it] to everyone, all the kids looked up to me. I was the only person on level 5, or whatever, and all the staff liked me and my parents were all happy.

* * *

It appears that the program has underestimated adolescents' needs for more opportunities to prove to themselves that they can manage everyday problems well enough that they will have a good chance of succeeding once they are discharged. While most of the adolescents indicated that they felt ready for their discharge at the time, they also indicated that in retrospect, they wished that more help would have been provided to make the transition out of the program and back into the community easier. Adolescents are quite worried, more than they let on, that they will "screw-up" after they leave the program. They desire to leave, but also fear failing. Thus, they need opportunities to develop self-confidence in their abilities.

The program attempts to deal with this problem by gradually allowing adolescents increasingly longer passes until eventually they are going on full weekend passes. This allows the staff and others (e.g. family) opportunities to assess the adolescents' strengths and weaknesses in order to determine where they need more help. It also provides opportunities for the adolescents to demonstrate to themselves that they're ready for more real independence, not the pseudo-independence that went along with the pseudo-maturity they presented at the beginning of the program.

This process is cumulative and proceeds until one week prior to discharge. Then they spend every night away from the program and are deemed to be day patients. However, from comments made by the adolescents, it appears that this latter time might be too short and a longer period of being a day patient, perhaps for two to three weeks, might be better.

Saying Goodbye

> Everybody was sad that you were leaving them but everybody was happy that you were moving on and getting along with your life.

* * *

> That part is really over, C.A.S.E. is really over for me and I don't really want to go through it again and why should I. . . I don't feel that I need to come in and say 'hi' and brag about how good things are going for me, I don't need that. It's just not something I need, I don't need the attention from everybody at C.A.S.E., you know. It's enough for me to drive by and look at my old bedroom window and sort of think.

* * *

> I know the problems to work on now before they get way out of hand. . .

* * *

One of the clearer demonstrations that adolescents are ready to relinquish help is by saying goodbye to their staff and peers. If all has gone well, they acknowledge that while there will be future problems, they are confident that they will be able to handle them. While sad and somewhat scared about the ending of this chapter in their lives, they also look forward to the beginning of the next one.

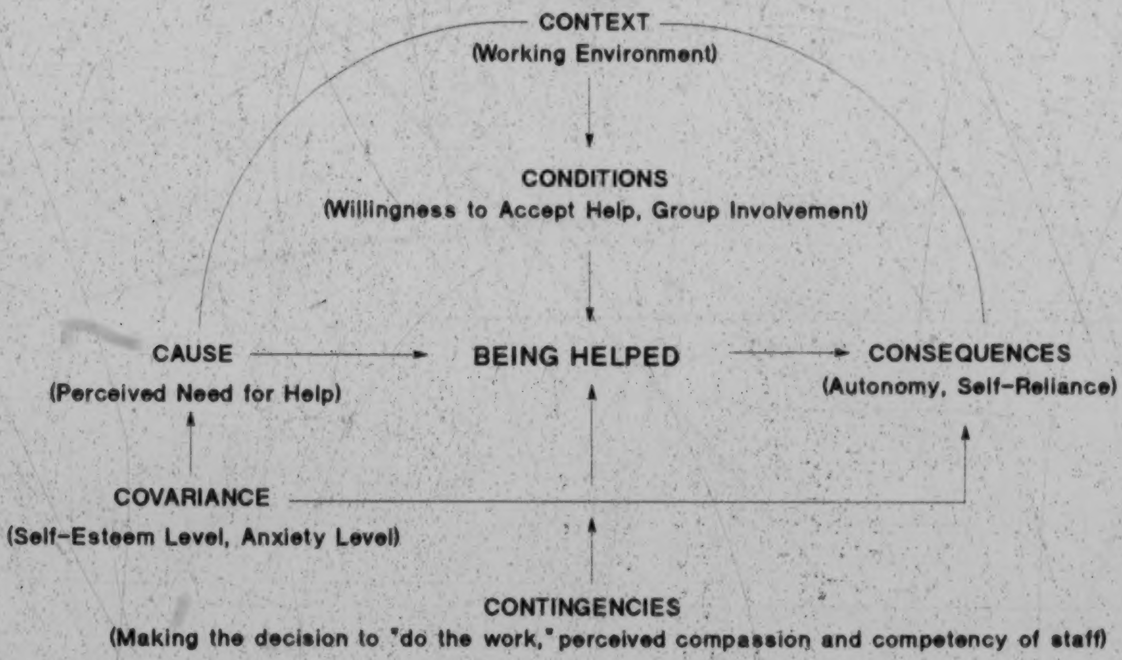

CONTEXT
(Working Environment)
CONDITIONS
(Willingness to Accept Help, Group Involvement)
CAUSE
(Perceived Need for Help)
BEING HELPED
CONSEQUENCES
(Autonomy, Self-Reliance)
COVARIANCE
(Self-Esteem Level, Anxiety Level)
CONTINGENCIES
(Making the decision to "do the work," perceived compassion and competency of staff)

Figure 7. Summary of the Process "Being Helped" using the 6C's method

Summary

When the BSPP of Being Helped is summarized using the six C's method, as in Figure 7, one again sees the interrelatedness of the two BSPP's.

In this diagram, **causes** of being helped are a perception on the part of someone that there is a need for help. This stems from the perception that the adolescent's problems are too overwhelming to be managed alone. The **consequences** of being helped will be that there is no longer a need for this kind of help (at least of this intensity or duration) and that the problems will no longer be overwhelming. Adolescents will be helped more easily if they perceive that they are being offered help within the context of a helpful, working environment, one that has elements of comfort, caring, and continuity to it. **Conditions** which affect adolescents' ability to be helped include their willingness to accept help, the degree to which they are able to become a working member of the therapeutic group, and the perceived competency and compassion of staff. Variables that appear to **covary** with this BSPP are again self-esteem and anxiety levels, as well as variables like trust and openness within the group. Lastly, how effectively adolescents are able to be helped is again **contingent** upon their decision whether or not to do their work and the perceived competency and compassion of the staff. Thus one can see that from the adolescents' perspective these two BSPP's are interdependent. For a treatment program to be effective, it would appear that each process has to be operating both adequately and harmoniously.

* * *

> The program did a small bit, like they kind of guided me along, put the groups in my path, the people in my path, the therapist, but I' say I did most of the work, me and my family. You know when we had family interviews and we'd work, my family did just as much work as I did, but in group, the therapy, the program really didn't do the work, I did the work, but I'm not saying that the program didn't help, like that it didn't do the, uh it's hard to explain. If it wasn't for the program I wouldn't be the way I am today, but it's because I did the work.

* * *

In closing this chapter, it appears that in the eyes of the successful adolescents, there are two essential processes that adolescents must become engaged in if they are to ultimately benefit from the program. On the one hand the adolescents indicate that each adolescent must do his or her work. Successful adolescents perceive that each adolescent has to make a commitment to work to the best of his or her ability to resolve his or her problems. On the other hand, the adolescents acknowledge that they cannot do it alone. They can only succeed if they are being helped. They see this help as coming from "the group" initially and then, hopefully, coming from their family or surrogate family. With the support of the group and the stability of the program, adolescents can be encouraged enough to do the work necessary to resolve their problems. They can face their problems, deal with difficult feelings, and then clarify and choose solutions. As they resolve their problems, they gain confidence in their abilities to handle future problems, and increasingly desire to return to the mainstream of life and to tackle problems in the real world. However, although they now feel more empowered, they still need to know that there will be back-up for some time to come. Having this continuity enables them to take the risk of saying goodbye to the program.

Having identified and described two critical processes based on the perspectives of the selected adolescents, it is now appropriate to examine the professional literature to determine whether these two BSPP's or aspects of them have surfaced in other instances.

CHAPTER SIX

INTEGRATION OF RESULTS AND LITERATURE

Introduction

Strauss and Corbin (1990) state:

> Since discovery is our purpose, we do not have beforehand knowledge of all the categories relevant to our theory. It is only after a theory has emerged as pertinent that we might want to go back to the technical literature to determine if this category is there, and if so what other researchers have said about it. (p. 50)

In chapters 4 and 5, the themes of "work" and "help" were identified as two concepts considered to be important by adolescents who had successfully completed an adolescent residential treatment program. In keeping with grounded theory methodology the literature was then surveyed for material relevant to these two concepts. The information obtained from this survey is presented in the first part of this chapter in conjunction with some of the results of the present study.

In the second part of this chapter, this information is integrated with the findings of this study to develop a more formal substantive theory of working and being helped that can be used by those involved in adolescent residential treatment. This theory and the model that accompanies it outline the basic components of the processes engaged in by adolescents and those helping them in a residential treatment program. However, this theory is presented at a more abstract level than the substantive theories presented in chapters four and five. Thus, this theory can be seen as the kind of "one-area formal theory" that serves as "a strategic link in advancing from substantive to formal theory" (Glaser, 1978 p. 144). Because this theory is more abstract it is possible that it might apply in situations outside a residential treatment situation.

Work

A review of the professional literature reveals that the notion of both patients and therapists having to do work in the psychotherapeutic setting goes back at least to Freud, as the following passage illustrates:

> Resistances were to be circumvented by the work [italics added] of interpretation and by making its results known to the patient; concentration on the situations giving rise to symptom-formation and on those which lay behind the outbreak of the illness was retained, while abreaction receded and seemed to be replaced by the work [italics added] the patient had to do in overcoming his critical objections to his associations. . . . (Freud, 1914/1963, pp. 157-158)

The idea that both therapists and patients (or clients) have "work" to do has been retained over the years by many different theoretically-based therapists. Therapists doing individual psychotherapy have long spoken of their patients or clients having to do "work" (Berne, 1972; Lowen, 1976). Group therapists have also spoken of not only the individual in the group having to do work (Perls, 1969), but also of the group as "working" (Bion, 1959) or having to do "group work" (Steiner, 1974; Yalom, 1985) which may or may not occur in "the working group" (Bion, 1959) or "workshops" (Fagan & Shepherd, 1970).

In addition to using the word "work" to refer to tasks that either the patient or therapist is expected to undertake in a therapeutic session, derivatives of the word "work" appear in two specialized terms in the psychoanalytic literature. The first is the term "working through" and the second is the term "the working alliance." Interestingly, working through has to do with therapeutic techniques, while the working alliance has to do with the therapeutic relationship. Each term thus appears to represent one side of the long-standing debate over which aspect of the therapeutic enterprise is more important - the therapeutic technique or the therapeutic relationship (Docherty, 1985; Gelso & Carter, 1985). As will be shown later, emphasis on both of these components by the adolescents suggests that they see both elements as important, a position more reflective of the views of current writers (Docherty, 1985).

Working Through

Working through, the oldest of the two terms, is a key concept when considering the tasks involved in psychoanalysis for the analyst and the patient. As a task for the analyst, it is one of the four main procedures involved in the larger task of analysis, the other three being clarification, confrontation, and interpretation (Greenson, 1967). From the analyst's perspective, working through refers to "the repetition and elaboration of interpretations which lead the patient from an initial insight into a particular phenomenon to a lasting change in reaction or behaviour" (Greenson, 1967, p. 98). Working through is what makes an interpretation effective. While clarification and confrontation prepare the way for a useful interpretation, it is working through that completes the analytic task (Greenson, 1967).

Robertiello (1978) has described "working through" from the patient's point of view very well. He says:

> "Working through" consists of demonstrating over and over again, the unconscious impulse from childhood in all its different forms and expressions. In the process of doing this, the impulse become conscious, the defences against it are diminished since they are no longer needed, and the impulse falls under the control of the ego. "Working through," thus, is an essential part of growth and change in the analytic situation. Without it there can be no real change. "Working through" is somewhat parallel to the attempt to master an impulse through repetition that is seen in children's play or the repetitive dreams in the traumatic neuroses. (p. 41)

From the analytic perspective, the specific procedures the patient uses in accomplishing this psychological work are such processes as "the utilization and the assimilation of insight and reorientation" (Greenson, 1967, p.29).

Although Yalom (1985) observes that the concept of working through has been virtually untouched by researchers, it is still seen as an important procedure today (Sholevar, Burland, Frank, Etezady, & Goldstein, 1989; Thorner, 1985). It also appears to be a term that may have relevance to adolescents in treatment as the following quotations illustrate.

* * *

> We were encouraged by the staff and by the other kids to bring [our problems] out into the open because not only would it help for us to hear ourselves talking and working through [italics added] the problems but it would also help other people that have been in similar situations to deal with them because together by talking and sharing it was a lot easier to communicate because you didn't feel like you were all alone in the world and your problems were so hard to deal with and so deep and so. . . just frustrating that there was nothing that you could do about them.

* * *

> R: So, looking back on it, how do you characterize your sleeping and reading behaviour. . . reflecting on that, [how] would you describe that kind of behaviour?
>
> Cl: Oh, avoidance of facing whatever, working here, working through your feelings and just progressing in the program.

* * *

From the above quotations, it appears that the adolescents are referring to something similar to Greenson's idea of working through. Although the context is different (group therapy rather than individual psychotherapy), it would appear that successful adolescents realize that one of their tasks in group therapy is to repeatedly express troubling problems (as well as encouraging others to do the same). Doing this enables the therapeutic group to help them through the procedures of clarification, confrontation, and interpretation. These procedures, in turn, enable adolescents first to acquire new insights and then to integrate these new understandings into their behaviour.

While the methods of encouraging adolescents to examine their problems are different in the group setting from that in the individual setting, it seems fundamentally that the same working through procedure is operating. It appears that when adolescents speak of "working through your problems," "working through your feelings," "working on your problems," or "working out your problems," they are engaged in the procedure analysts label "working through" (provided, of course, that they are receiving appropriate help from the therapeutic working group). Furthermore, as was indicated in the results earlier, it appears that successful adolescents recognize their role in this procedure and assign much importance to it. However, this may not be the case for unsuccessful adolescents.

* * *

> R: Tell me a bit about what you mean by 'working' because other kids have used this phrase too and I'd like to understand what it means.
> Cl: Well "working" as in talking and just being a decent person, but brown-nosing isn't the way. Working also means to me, on fairly decent behaviour.

R: Some kids have used the phrase "working through their problems" or "working on their problems." Does that make any sense to you?
Cl: Not really. I don't know how you can work on your problems, like I don't know how you could really work on them because if you have a problem outside of here then how are you going to work on it being here. That kind of a thing I don't get.

* * *

R: How come the program didn't help with your family? Or should I put it in another way. Is there anything they should have done or you wished they would have done?
Cl: No, because like the way my mom is, is like that, I guess. She was kind of stubborn and so was I. I don't know, we didn't really work hard enough on my mom's and my relationship I guess.
R: You and your mom or the program?
Cl: Me and my mom or the program. We did for a while but then, I don't know, I wanted to get out, like I didn't want to live at home any more.

* * *

As the first quotation above shows, it seems possible that unsuccessful adolescents fail to understand fully either their role in the procedure of working through or the tasks necessary for them to accomplish. However, as the second quotation illustrates, even if they do perceive their role and their tasks, they may, for some reason, still fail to fully immerse themselves in the process.

Given the significance of the procedure of working through, where does it fit into the BSPP of Doing Your Work? Because Doing Your Work involves additional processes encompassed by the terms "Being Readied to Work" and "Completing the Work," it clearly entails more than just the procedure of working through. Even the central process in the BSPP of Doing Your Work, the process labelled "Working," also appears to incorporate and elaborate more than the procedure of working through. However, within this latter process, the concept "Working on Your Problems" seems to closely parallel the procedure of "working through." It appears the two terms - working on your problems and working through - are essentially synonymous.

The Working Alliance

The other psychoanalytic use of the word "work" has to do with the term "the working alliance" (Greenson, 1967). This term and associated terms such as "the working relationship" (Greenson, 1967), "the helping relationship," "the helping alliance" (Luborsky, 1976), and, in particular, "the therapeutic alliance" (Zetzel, 1956), appear to have much significance for this study. This is because the concepts encompassed by these terms seem to articulate best many of the phenomena involved in the interaction between the two themes identified in the present study - "work" and "help."

The working alliance and the other terms just mentioned refer to aspects of the therapeutic relationship that develop between the therapist and the patient. Although analysts have not been the only ones interested in the therapeutic relationship (e.g., Rogers, 1957), it is their writings to which most modern-day researchers in this area refer (Gelso & Carter, 1985).

Within psychoanalytic circles, concepts associated with "the working alliance" (and other related terms) arose out of a dissatisfaction with a perceived overemphasis on traditional psychoanalytic techniques for certain kinds of patients (e.g., narcissistic, borderline, or psychotic disorders). This dissatisfaction was based on the perception that for these kinds of patients the therapeutic relationship deserved more attention as a curative factor than had previously been given to it (Frieswyk, Colson, & Allen, 1984).

Credit for developing the concept of "the working alliance" has generally been given to Greenson (Kokotovic & Tracey, 1990). Greenson (1967) saw the patient-analyst relationship consisting of three separate but overlapping components: the transference relationship, the working alliance, and the real relationship (Kokotovic & Tracey, 1990). Greenson defined the working alliance as "that part of the patient-analyst relationship that enables the patient to identify with the analyst's point of view and to work with [italics added] the analyst despite the neurotic transference reactions" (Greenson, 1967, p. 29). Greenson went on to say that the working alliance refers to "the relatively nonneurotic, rational rapport which the patient has with the analyst. It is the reasonable and purposeful part of the feelings the patient has for the analyst which makes for the working alliance" (Greenson, 1967, p. 192). Greenson stated that the term was selected because it emphasizes its outstanding function – the patient's ability to work in the analytic situation. He also said that the term is best illustrated when one sees a patient is in the "throes of an intense transference neurosis and yet can still maintain an effective working relationship with the analyst" (Greenson, 1967, p. 192).

Today the working alliance is sometimes both equated with the term "therapeutic alliance," and sometimes differentiated from it (Freebury, 1986; Kokotovic & Tracey, 1990; Hartley, 1985; Marcus, 1988).

The Therapeutic Alliance

Although the term "the therapeutic alliance" was first coined by Zetzel (1956), suggestions of the concept can be found in the writings of Freud (Marcus, 1988). Later, Sterba (1934) and Bibring (1937) provided elements of the ideas that Zetzel was to formulate into the concept of "the therapeutic alliance." Like Greenson's (1967) idea of the working alliance, the therapeutic alliance refers to the process whereby the healthy part of the patient's ego is co-opted into a constructive working relationship with the ego of the analyst (Zetzel, 1956).

The therapeutic alliance is also similar to the working alliance because it too is generally used to emphasize the importance of the patient-therapist relationship in facilitating a corrective emotional experience (Zetzel, 1956) along with the quality of work the patient does in the treatment process (Frieswyk et al., 1984). However, Frieswyk et al. (1984) also note that the therapeutic alliance has been used rather loosely at other times to refer to various aspects of either patient activity or analytic technique. Zetzel's emphasis on the relationship with the patient signalled a shift away from the traditional emphasis on interpretation as the major curative factor for some patients (Frieswyk et al., 1984).

Later Refinements of the Alliance

Following Greenson's and Zetzel's focus on the constructive aspects of the therapist-client relationship, others also began to stress the importance of the alliance. Bordin (1979) extended and refined Greenson's thinking with his conceptualization of the working alliance. He demonstrated that although the concept of the alliance originated in psychoanalysis, it is applicable to a broad spectrum of therapies. Bordin defined the working alliance as a combination of three related components: (a) client and counsellor agreement on the goals of treatment (goal), (b) client and counsellor agreement on the tasks to achieve these goals (task) and (c) the development of a personal bond between client and counsellor (bond).

Based on the above definition and the information gathered in this study, it appears that the concepts covered by the two BSPPs identified in this study correspond closely to the concepts covered by Bordin's definition. It appears that the BSPP identified in this study as "Doing Your Work" covers the first two components of Bordin's definition (goal and task), while the BSPP identified in this study as "Being Helped" covers the third component of his definition (bond).

Interest in the concept of the alliance has led to the development of a number of instruments designed to assess either the working alliance or the therapeutic alliance. Based on Bordin's work, Horvath and Greenberg (1986, 1989) developed an instrument, called the WAI (Working Alliance Inventory), to assess his three components of the working alliance. While still somewhat controversial (Kivlighan, 1990), the WAI is often used today to help assess both therapists' and clients' perception of the working alliance (Kivlighan, 1990; Kokotovic & Tracey, 1990). Hartley (1985) reviews a number of the instruments designed to assess the therapeutic alliance. Taken together, the research obtained from the use of these various instruments has shown that the working or therapeutic alliance is a significant variable affecting therapeutic outcome.

Today, it seems "the therapeutic alliance" rather than "the working alliance" is the term used most frequently. Despite continued interest in the concept of the working alliance, the trend seems to be toward either equating it with the therapeutic alliance (Freebury, 1989) or incorporating it as one component of the therapeutic alliance (Marcus, 1986). Illustrating the popularity of the latter term, a computer search of articles related to these two terms revealed nearly three times as many articles on the therapeutic alliance (223) as on the working alliance (81). However, if one considers the views of the adolescents in this study, it seems that the label of the working alliance might have more appeal to them than the more academic label of the therapeutic alliance.

If, however, one ignores the dispute over the labels used for the underlying phenomena, and concentrates on the phenomena instead, one finds that in the last decade contemporary psychology has given increasing importance to the alliance that is formed between the patient and therapist as they address the patient's problems (Frieswyk, Allen, Colson, Coyne, Gabbard, Horowitz, & Newson, 1986; Kivlighan, 1990).

Therefore, while acknowledging that there are still strong differences of opinion about the precise meaning of each of these two terms (compare Frieswyk, Colson, & Allen, 1984 and Saunders, Howard, & Orlinsky, 1989), and acknowledging also that there are different opinions about whether these two terms are indeed equivalent (Gelso & Carter, 1985; Marcus, 1986), for the purposes of this paper these two terms will be treated as equivalent. What is important for this paper are the phenomena these two terms are attempting to capture, namely the helpful aspects of the working relationship between the therapist and the patient. Bordin's comments are useful here. He sees the working alliance as a more generic term. He suggests that it is possible that:

> A working alliance between a person seeking change and a change agent can occur in many places besides the locale of psychotherapy. The concept of the working alliance would seem to be applicable in the relationship between student and teacher, between community action group and leader, and, with only slight extension, between child and parent. (Bordin, 1979, p. 252)

Although Bordin goes on to choose the term "working alliance," he first speaks of "the therapeutic working alliance," seemingly indicating that the therapeutic alliance is one type of working alliance. This is an approach that seems compatible with the findings of this study.

* * *

> They basically teach you values over I guess, and the great part of it, is due to the staffing. I don't know how you guys choose your staff but you do a very good job of it. They're all really great people and they all have an integral part in developing the students or

> helping the patients' relationships. In turn the other kids do too, the other kids help. . . who helps the most. . . a toughie. . . because there are so many different attitudes and so many conflicting people, everyone's different, I think there's so many conflicting beliefs, not conflicting but complex and different ideas, that someone would be, they'd just be overwhelmed, to try to assimilate everybody and come up with a general idea. So, I'd have to say that the key worker and your primary therapist are two of the main teachers along with your parents. It's an interactive process and then your peers and the staff in general.

* * *

The findings of this study suggest that one of the components adolescents see as crucial to their success is the development of a positive relationship, an alliance, between the members of the therapeutic group (the helpers) and the adolescent (helpee) as the adolescent "works through" his or her problems. Although the adolescents did not use the term "working alliance," it seems that this is what they are referring to when they report how their relationships with the other adolescents or staff helped them to change.

As an aside, it might be noted that although this researcher saw clear examples of transference occurring in the treatment program at times, the adolescents' comments did not often refer to this process. Instead, their comments referred to concepts associated with the working alliance. This suggests that while transference may be an important concept to many psychotherapists, it may not be seen as very important by these kinds of adolescents.

However, the notion of the working alliance does seem to be important to them. Therefore it appears that emotionally disturbed adolescents could also be included in that group of patients mentioned earlier who seem to benefit when the therapeutic relationship is emphasized as a curative factor.

Returning to the main discussion, based on the information provided by the adolescents, it appears that two important components involved in the development of the working alliance are the processes of Working and Being Helped. The first is performed by both the helper and the helpee, while the second is primarily received by or accepted by the helpee.

In this writer's opinion, it would seem that if these two processes (Working and Being Helped) are appropriately present, a working or therapeutic alliance naturally results. Therefore, these two processes seem to be quite compatible with whatever term is used. In fact, rather than using either of these terms, Luborsky (1976) prefers to use the term "the helping relationship." By doing this he illustrates, perhaps unintentionally, how the two themes of work and help interact together. It seems that Luborsky has simply chosen to emphasize the helping aspect of the relationship rather than the working aspect of the relationship.

Refinement of aspects of the two terms "the working alliance" and "the therapeutic alliance" is still ongoing. The next section of this paper will look more closely at present-day researchers' views of one important aspect of these two terms.

Quality of the Alliance

Once the importance of the therapeutic relationship in affecting psychotherapeutic outcome was established (Luborsky & Auerbach, 1985; Frieswyk et al., 1986), researchers focused more closely on the quality of the therapeutic relationship. Today, most researchers accept that the quality of the relationship, especially the quality of the alliance, between the patient and therapist is a major determinant of psychotherapeutic effectiveness (Kokotovic & Tracey, 1990; Saunders, Howard & Orlinsky,1989). However, they differ about the type and nature of the dimensions of the alliance that should be examined to determine its quality (Kokotovic & Tracey, 1990). Before focusing in on the dimensions used to assess the quality of the alliance, a broader perspective will be taken first.

Hartley (1985) observes that anyone studying a psychotherapy session needs to acquire the perspective of each participant in the session, i.e., the therapist, the client, and the observer. She cites Orlinsky (1983) for support of this tripartite approach. He says:

> Anyone who would study therapy processes may legitimately study it from any one of these perspectives: what the patient experienced; what the therapist experienced; what the nonparticipant observer experienced. On the other hand, anyone who wants to study psychotherapy process as a whole must study it from all three perspectives and must include the congruences and divergences of these perspectives as part of the data. (Orlinsky, 1983, p. 5)

Therefore to fully capture an understanding of the quality of the working alliance, one would need to first identify the critical dimensions determining the quality of the relationship, and then obtain the views of each of the participants and observers regarding these dimensions.

Having said this, and bringing the focus of the discussion back to the dimensions involved in assessing the quality of the alliance, one dimension often examined is the strength of the alliance. According to Kivlighan (1990), it appears most researchers today believe that the strength of the alliance is affected by three factors. These are: (a) client pretherapy characteristics (e.g., ability to form interpersonal and family relationships, expressed levels of hostility, levels of adjustment to stress, types of presenting problems), (b) therapist personal characteristics (e.g., decency, openness, friendliness, maturity), and (c) therapist technical activity (the "how" and "why" of therapist interventions).

Taking a tripartite approach to assessing the effect of this dimension of the quality of the alliance (on the therapeutic alliance as a whole) would mean obtaining information from each of the participants and observers. However if one could take only one perspective, logic would seem to dictate that it be the client's perspective (at least for the long-term view).

Rogers (1957) emphasized long ago that even if the "necessary" and "sufficient" facilitative conditions for therapeutic change are objectively present, if the client does not perceive them to be present, then the therapeutic process can not be initiated. Common sense would also seem to support obtaining the client's perspective, especially if one views the client as a consumer who is technically paying for a professional service, even if only by the investment of his or her time and effort. However, perhaps not surprisingly, soliciting the viewpoint of the client has been more the exception rather than the rule.

Until recently, most systems for measuring the quality of the therapeutic relationship have been based on the perspective of the non-participant observer (Saunders, et al., 1989). However, this is changing and more researchers are now emphasizing the client's perspective, especially now that it has been repeatedly shown that it is the patient's perception of the quality of the relationship that is "most consistently positively related to outcome" (Saunders et al., 1989, p.323). Applying this information to the present study, it can be seen that despite the opinions objective observers might have about the factors necessary to strengthen the therapeutic relationship (e.g., trying to make the adolescent feel more comfortable), ultimately it is the adolescents whose perceptions are most important.

Interest in the patient's perspective of the quality of the relationship has led to further refinements in understanding and conceptualization of the alliance. Two refinements in particular appear useful to the present study.

The therapeutic bond. Orlinsky and Howard (1978, 1986, 1987) have chosen to focus on that aspect of the alliance that Bordin would refer to as the third component of the working alliance, i.e., "the bond." Orlinsky and Howard (1987) refer to personal qualities of the relationship between the therapist and client as "the therapeutic bond." For them, focusing on the therapeutic bond allows one to assess the strength of the therapeutic relationship. The concept of the therapeutic bond is useful for the present study because it is important to be aware of how much stress an adolescent can withstand before he or she will stop working with a therapist. Presumably if the bond is stronger, the adolescent will be able to withstand more stress.

Orlinsky and Howard (1987) suggest that their conceptualization of the therapeutic bond has extended previous ideas about the therapeutic alliance. They state:

> The therapeutic alliance is a compact between patient and therapist to cooperate in performing their respective roles. The therapeutic bond, on the other hand, extends beyond patient and therapist roles to include certain personal qualities of the relationship that forms—or fails to form—between the participants. (Orlinsky & Howard, 1987, p. 10)

Saunders, Howard & Orlinsky (1989) see the therapeutic bond being composed of three dimensions that can be used to assess its quality. The first reflects the "energy" or "investment of self" that each participant invests in his or her respective role in the psychotherapeutic process. They have chosen to label this dimension "the working alliance." While one can appreciate their attempts to clarify understanding of the therapeutic bond, choosing the label "the working alliance" for this aspect of the therapeutic bond appears to be an unfortunate choice of terms. Although this label attempts to provide more precision, given the previous existence of the term "working alliance," using it this way may simply result in more confusion. Furthermore, by referring to "personal qualities of the relationship" and "an investment of self," one wonders if this component might not be more properly viewed as referring to the "real self" of which Greenson (1967) spoke earlier.

The second dimension is entitled "empathic resonance." It refers to both the patient's and therapist's sense of understanding and being understood, of "being on the same wavelength." The third dimension is called "mutual affirmation" and is considered by Saunders et al. (1989) to be conceptually close to the Rogerian concept of unconditional positive regard. This dimension emphasizes reciprocity of caring, but recognizes that caring, while normally experienced as warmth and acceptance, may on occasion lead to confrontation and challenge. It is "an interest and endorsement of (the other's) well-being, motivating behaviour that is essentially caring in quality" (Orlinsky & Howard, 1986, p. 348).

Together these three dimensions comprise the therapeutic bond. Saunders et al. (1989) stress that the therapeutic bond is a reflection of the interaction between the participants, not a quality of the participants themselves. This is a distinction that is hard to appreciate in light of Klivighan's (1990) earlier assertion that client characteristics affect the strength of the alliance. However, despite some difficulties with Orlinsky and Howard's conceptualization of the "therapeutic bond," their research is useful, and will undoubtedly stimulate further work on the therapeutic alliance.

Collaboration. The other refinement of the alliance that appears useful to this study is that initiated by Frieswyk, Colson, and Allen (1984). They have chosen to separate the patient-therapist affective aspect of the therapeutic relationship (the "therapeutic bond," using Orlinsky's and Howard's term) from the quality of the work occurring in the therapeutic process. Focusing in on the latter, they have advocated that the alliance be defined more narrowly as "the patient's active collaboration in the work of psychotherapy and psychoanalysis" (p. 460). By collaboration they mean "the extent to which the patient makes active use of treatment opportunities for constructive change" (Allen, Deering, Buskirk, & Coyne, 1988, p. 291). They believe that by doing this, it is possible to distinguish the alliance from both various aspects of the patient's experience of the relationship (especially transference) and issues of technique. This, they suggest, will eventually permit empirical investigations of the impact of the various therapeutic strategies and techniques upon the alliance. Put another way, the authors contend, this will mean that:

> The state of the alliance can then be viewed as a barometer of therapeutic change reflecting in its variation the impact of specific treatment interventions both in their immediate effects as well as in their cumulative impact on the treatment process and its outcome. (Frieswyk et al., 1986, p. 32)

While defining all of the alliance as collaboration does not seem helpful for the present study, emphasizing the notion of collaboration as one aspect of the quality of the working alliance does seem useful. The idea of a patient and therapist working together rather than working against each other makes sense intuitively. Once again, this is a idea that seems to be compatible with the results of the present study.

On balance, what the research in this area of the alliance suggests that is important for the present study is that for many patients the quality of the relationship (between the helper and helpee) is equally if not more important than the nature of the technical interventions (e.g., interpretations).

* * *

> . . .all [the staff] were very, I guess I'll just have to say, warm, open, warm — well not open — friendly people, in a patient-doctor kind of relationship.

* * *

> . . .they were really interested in what we were doing . . .they would always be with us. If we were sitting playing crafts they'd always be sitting there talking to us about little things, chit-chat, um. . . These people were always really polite, always! They were, really nice and understanding and you could feel them, you could feel their caring. You could sense it.

* * *

> I think that's the most important thing that the C.A.S.E. program tries to offer everybody, is that. . . the ideology that they care and that they want to help.

* * *

> The groups actually were really helpful. Being able to talk and not have anybody say anything back to you like, or put you down for what you've said. . . .

* * *

> I thought that our group was so close that, I remember everybody was so close in our group, for about for two months nobody new came in and nobody new left. Our group was just so close it was like, we could of been in separate rooms forever and still of felt caring for each other.

* * *

When the comments of the adolescents in the present study are examined, it appears that they also perceive that the relationships they have with each other and with the staff are important to them. However, it is not clear from these quotations whether they see relationships as more important than technical interventions.

The alliance in the therapeutic milieu. Unfortunately, there is little research elsewhere that would answer the question of what is most important in the therapeutic milieu – the therapeutic relationships or the therapeutic techniques. This is because while there is a "burgeoning" body of literature on the alliance in the area of individual psychoanalysis or psychotherapy, there are relatively few references to the role of the alliance within a residential or hospital setting (Allen, Deering, Buskirk, & Coyne, 1988), and even fewer having to do with adolescent residential treatment (O'Malley, 1990). Even though Colson and Coyne (1978) noted some time ago that "the quality of the therapeutic alliance is prominent in the thinking of all members of the [multidisciplinary] team" (p. 420), it appears that the complexity of researching this concept outside of the therapist-patient dyad has deterred researchers (Allen et al. 1988). Given that the present study would appear to lend support to the importance of the concept of the alliance, particularly in the eyes of adolescent patients, it is hoped that more researchers will try to grapple with the concept of the alliance within a therapeutic milieu.

Help

Although the concept of help has already been discussed under the heading of "the working alliance," this section will briefly examine another one of the areas in the literature where this concept has been discussed. Because help is such a broad term, it is beyond the scope of this review to examine the variety of ways the word has been used in the therapeutic literature. Numerous books and articles have been written about how the therapist can be "helpful" to his or her clients. This study is only one of many that has showed that in order to be ultimately successful, clients must "be helped." To do this, of course, "helpers" must "be helpful." Because this study suggests that adolescents perceive group therapy to be the main vehicle of change, this next section will turn to the literature of group therapy and group processes for information about being helpful.

The focus of this discussion will be on those factors considered in the literature to be helpful in promoting change. Fortunately, this area has been researched reasonably well. The classic text in this area is Yalom's thrice-revised book The Theory and Practice of Group Psychotherapy (1985).

Yalom (1985) starts the first chapter of his book with a seemingly simple question: "How does group therapy help patients?" (p. 3). Yalom goes on to suggest that therapeutic change occurs "through a intricate interplay of various guided human experiences" (p. 3), which he once referred to as "curative factors" (Yalom, 1970) but now prefers to call "therapeutic factors" (Yalom, 1985). His research indicates that these factors can be divided into the following eleven primary categories:

1. Instillation of hope
2. Universality
3. Imparting of information
4. Altruism
5. The corrective recapitulation of the primary family group
6. Development of socializing techniques
7. Imitative behaviour
8. Interpersonal learning
9. Group cohesiveness
10. Catharsis
11. Existential factors. (p. 3-4)

After suggesting that these are the crucial factors, Yalom (1985) goes on to provide examples from the research to support this hypothesis. Among other studies, he cites one in which he investigated the curative factors in twenty successful long-term adult therapy patients (Yalom, Tinklenberg, & Gula, 1968). According to this investigation, which used a sixty-item, seven-pile, Q-sort to obtain the data, insight (e.g., Discovering and accepting previously unknown or unacceptable parts of myself) was considered the most important curative factor by the majority of the patients. The next most important factor was catharsis (e.g., Being able to say what was bothering me instead of holding it in). Seven of the first eight items chosen most frequently represented some form of catharsis or "insight." He cites this finding to support his assertion that "therapy is a dual process consisting of emotional experience and reflection upon that experience" (Yalom, 1985, p. 75).

However, all of the research cited by Yalom was done with adult patients. No research examining adolescents' perceptions of curative factors was presented. To remedy this, Corder, Whiteside, and Haizlip (1981) conducted research on adolescents' perceptions of the curative factors in group psychotherapy. They reported that prior to their research no research had been done investigating adolescents' perceptions of the curative factors in group psychotherapy, even though many authors had described "significant differences between psychotherapy goals and techniques for adolescents and adults" (p. 346).

The research done by Corder et al. (1981) indicated that while there were some very similar patterns of perceptions of curative factors (e.g., catharsis and existential factors) in both their adolescent group and the adult group studied by Yalom, adolescents assigned more importance to catharsis (e.g., Being able to say what was bothering me; Learning how to express my feelings) and less importance to insight than did the adult group. The authors also found that adolescents emphasized aspects of group cohesiveness (e.g., Belonging to a group of people who understood and accepted me), universality (e.g., Seeing I was just as well off as others), and altruism (e.g., Helping others and being important in their lives), along with items that related to the importance of interrelationships among group members (e.g., Other members honestly telling me what they think of me; Being in a group was in a sense like being in big family. . .) more than the adult patients did.

The present study is not a quantitative study. Therefore it is concerned only with the generation of categories, not the quantification of categories. However, only one item from the list of the ten most frequently chosen curative-factor items reported by Corder et al. – the interpersonal learning (output) category (e.g., The group's giving me an opportunity to learn to approach others) – was not found in the present study. In fact, the descriptions of the ten most frequently chosen items in Corder's study are so similar to examples already quoted in this study that the examples are not repeated here. Furthermore, based on the subjective impression of the adolescents' comments in this study, it appears that they (the adolescents) are similar to the adolescents in Corder's study because they also emphasize the value of catharsis more than the value of insight. Therefore, it would appear that the information in the present study complements and confirms the information obtained by Corder et al. (1981). It also supports Yalom's earlier assertion that to be effective, treatment must be an emotional as well as an intellectual experience.

A Theory of Working and Being Helped

In this next section, a more formal substantive theory of working and being helped is presented. This theory is based primarily on the integration of concepts from three sources. These concepts and sources are: (a) the two BSPPs – Doing Your Work and Being Helped – identified earlier in this study, (b) some of the ideas presented earlier in this chapter – especially those by Luborsky (1976) and Bordin (1979), and (c) concepts from the organizational development literature (e.g., Cohen & Smith, 1976; French & Bell, 1973; Hersey & Blanchard, 1982).

Using the techniques of "rewriting" and "reworking" discussed by Glaser (1978), the substantive theories of working and being helped in an adolescent residential setting are integrated and elevated to a more abstract level in order to develop a more formal substantive theory. This resulting theory can then be used as a link from a substantive theory about adolescents working and being helped in a residential treatment centre to a fully grounded formal theory about working and being helped which is applicable to many substantive areas and is supported by data from many diverse substantive theories (Glaser, 1978).

Furthermore, by using the two BSPPs as the basis of the link from simple substantive theories to a more formal substantive theory, a generic model of working and being helped can be developed. By elevating the two BSPPs to a more abstract level and by focusing on their essential nature - the accomplishment of various tasks facilitated by evolving relationships in the service of desired goals - a model can be developed that illustrates the key components involved in these two processes as they unfold. This model is schematically represented in Figure 8. Following this illustration, the model and the theory it represents are discussed in more detail.

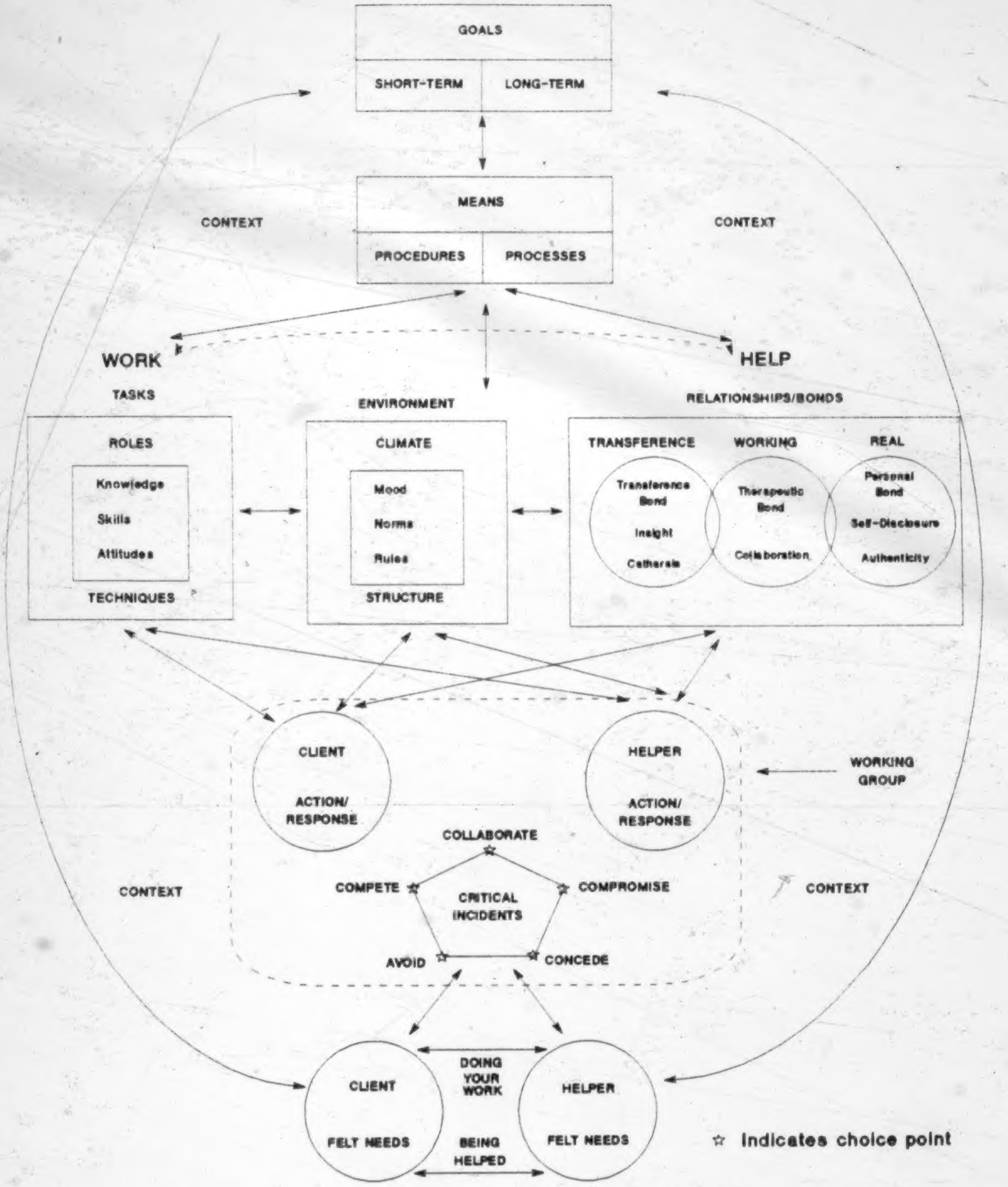

GOALS
SHORT-TERM
LONG-TERM
MEANS
PROCEDURES
PROCESSES
CONTEXT
CONTEXT
WORK
HELP
TASKS
ENVIRONMENT
RELATIONSHIPS/BONDS
ROLES
Knowledge
Skills
Attitudes
TECHNIQUES
CLIMATE
Mood
Norms
Rules
STRUCTURE
TRANSFERENCE
WORKING
REAL
Transference Bond
Insight
Catharsis
Therapeutic Bond
Collaboration
Personal Bond
Self-Disclosure
Authenticity
CLIENT
ACTION/ RESPONSE
HELPER
ACTION/ RESPONSE
WORKING GROUP
COLLABORATE
COMPETE
COMPROMISE
CRITICAL INCIDENTS
AVOID
CONCEDE
CONTEXT
CONTEXT
CLIENT
FELT NEEDS
DOING YOUR WORK
BEING HELPED
HELPER
FELT NEEDS
☆ Indicates choice point

Figure 8. A model of Working and Being Helped based upon the two BSPPs: "Doing Your Work" and "Being Helped"

The model is designed so that it can be examined by starting from either the top or the bottom of the diagram. Starting from the top of the diagram, one would begin with "Goals" and then move downwards to examine the procedures and processes that enable these goals to be achieved. Starting at the bottom of the diagram allows one to begin with the two basic social psychological processes, "Doing Your Work and Being Helped" - now abstracted to a higher conceptual level to include any situation that involves a successful collaboration between one party being helped by another party. Moving upwards from this segment of the diagram allows examination of the key components in the two processes that occur when two parties interact with each other as they attempt to attain desired goals.

Premise of the Model

The premise of this model is contained in the lower section and in the segment that shows one party, the client system (an individual or group needing help at any given time), and another party, the helper system (the individual or group offering help), interacting through the two (now generic) processes - Doing Your Work and Being Helped. In this segment of the model, both parties are viewed as working towards goals and being helped by each other to achieve these goals. This is true both in situations where one party is designated as the formal helper (e.g., a therapist) and the other as the helpee (e.g., a patient), and in situations where one party has informally or temporarily stepped into the role of helper (e.g., one neighbour helping another neighbour). The premise of this model is that in order to achieve mutually desired goals, two parties must eventually collaborate together. This means that the two parties cannot achieve their goals unless both do their work and both are being helped by each other. The effective integration of the two processes, doing your work and being helped, results in the creation of an overall process - collaborating.

Overview of the Model

Beginning with an overview of the model before examining it more closely, the bottom section of the diagram shows two parties entering into a situation of proximity. Each is motivated by a variety of felt needs (Schein, 1969) to achieve certain goals, either explicitly or implicity stated. To achieve these goals, each party must accomplish certain tasks - meaning they must engage in the generic process of "doing your work." They must also develop working relationships or alliances, thus involving them in the generic process of "being helped." This provides them with the support and resources to accomplish their tasks, and doing this results in the creation of a "working group," which is defined as a group consisting of a client system and helper system working collaboratively towards mutually desired goals. In order to achieve these goals, the working group must develop methods and procedures that allow: (a) the necessary tasks to be performed, (b) the creation of a working environment that will facilitate the performance of tasks, and (c) the development of working relationships that will both help to accomplish the necessary tasks and to maintain the working environment.

The specific work required of each client will depend on the substantive area involved. Examples of the specific tasks necessary for an adolescent patient/client to perform in the setting of an adolescent residential treatment centre have already been discussed. In the situation of the traditional therapist/patient dyad the generic "work" of the therapist/helper is "helping." The therapist will only be able to help if the patient/client helps by "doing his work" or by "doing her work." Thus, when it is "working" effectively, one of the mutual generic tasks of the client/helper system is collaborating.

Examination of the Model in More Detail

The Inevitability of Conflict

Beginning at the bottom of the diagram, the model shows that as two parties begin to work towards their goals, their interactions with each other will eventually result in conflict. One of the assumptions of this model is that the parties will differ about how best to proceed with the necessary tasks in order to achieve their desired goals. Another assumption underlying this model is that differences of opinion will eventually catalyze various conflicts both internally (within either the client or helper systems) and externally (between the client and helper systems). In turn, these conflicts will be manifested in events labelled "critical incidents" (Cohen & Smith, 1976) which, in turn, will place the parties at "choice points" (Tauber, 1978) where decisions must be made by each party about the procedure they will use to resolve their differences. Each of these conflict situations or critical incidents is resolved by the parties choosing/using one of five basic conflict resolution modes. Each party can choose to: (a) avoid the conflict, (b) concede to the other party, (c) compete against the other party, (d) compromise with the other party, or (e) collaborate with the other party. Arriving at a choice point always results in a response and subsequent action by a party. Even the decision to not make a decision will still result in some kind of action. Furthermore, as decisions are made about how to resolve conflicts and as subsequent actions flowing from these decisions form into patterns, a continuing process of definition occurs. This process results in the increasingly accurate definition of the tasks to be performed, the nature of the developing relationships and the form of the working environment.

Moving into the centre of the model, it can be seen that the tasks, working environment, and relationships all reciprocally influence and shape each other. In each case "boxes within boxes" are used to illustrate the crucial components and their constituents.

Tasks

To achieve the desired goals, members of the working group have to accomplish certain explicit or implicit tasks. This segment of the model is concerned with those components (and their qualitative dimensions) which must be considered when thinking about these tasks. Moving inside the first box, it can be seen that tasks have two main components to be considered: roles and techniques. The concerns addressed by these components, stated in question form for more clarity, are: (a) What are the roles the parties will need to assume to accomplish their tasks?, and (b) What are the techniques that can be used to help accomplish these tasks? In order to successfully perform their respective tasks, both the client and helper need to be clear about their respective roles. The more role clarity and consensual agreement about roles exist between the parties, the easier it will be for each party to do the required work. Disagreement between the parties about their respective roles means that there will be conflict that will, to some degree, affect the efficiency of the parties' collaborative efforts.

The effectiveness of the parties in performing their tasks is affected by the techniques they are using. In turn, the knowledge, skills and attitudes each party brings to the situation (as shown by the most interior box) affect the quality both of the roles assumed and the techniques employed.

The Working Environment

There are two important components of the working environment to be examined when considering its influence upon the tasks being performed and the relationships affecting task performance: the climate and the structure. Other words for climate might be atmosphere or ambience, and useful questions here are: (a) What is the climate - physical, emotional and intellectual - in which the work of the group is taking place?, and (b) How is this climate affecting the efficiency of the working group?

Structure refers to the organization of the physical and mental environment, and a question here might be: How is the present structure operating in the working group affecting the quality of the work being performed? More specific questions to assess climate and structure are triggered by examining the box containing key words such mood, norms, and rules.

In addition to functioning as an influence on the tasks and relationships factors in this model, the working environment is also embedded in many contexts, e.g., the context of physical plant and architecture, a socio-cultural context, a political-economic context, and a qualitative/ quantitative context, to name but a few. All of these different contexts shape the meaning ascribed to the actions of each of the parties.

Relationships

The relationships component of this model suggests that there are three kinds of overlapping relationships that affect the nature of the bonds that are formed between the client system and the consultant system: (a) the transference relationship, (b) the working relationship or working alliance, and (c) the real relationship. All of these terms were defined earlier in this chapter.

While a transference relationship may or may not facilitate goal attainment, a working relationship always has to be developed (to some degree) in order for a working group to proceed towards its goals. However, while a working relationship may not be present if a client/helper system has not yet formed a working group, there will always be elements of the other two kinds of relationships in the overall relationship that is formed between any client system and helper system.

The degree to which a transference relationship or a real relationship is formed depends in part on the nature of the tasks to be performed and the goals to be achieved. For example, if the helper is in the role of analyst and the client is in the role of patient, and the techniques of analysis are skilfully employed, a great deal of transference towards the analyst will likely occur and will ultimately be seen by both parties as desirable. However, if the helper is in the role of spouse and uses some techniques for providing support which instead of promoting closeness arouse strong transference feelings, this will most likely be seen as undesirable by the couple. To use one more example, if a foreman and a crew of carpenters are building a house together they are not likely to be very interested in developing any kind of relationships other than the effective working relationships which will allow them to complete their project on schedule. However, either the transference element or the real element of their overall relationship may positively or negatively affect their working relationship. For example, a crew-member may look upon his foreman as the "ideal father" and may initially work very hard for his boss, only to become very difficult to work with later when his foreman/father fails to meet some covertly expressed request. Similarly, a foreman who has hired a friend to work with him may have difficulty assertively stating the job expectations he demands in order to accomplish required tasks on schedule.

Means, Procedures, and Methods

Each of the three components – tasks, working environment and relationships – affect the next higher level in the model, namely the means or the specific methods and procedures used to achieve the goals. For example, using the present study for illustration, one could say that residential treatment is the means for helping an adolescent achieve the desired goal of adaptive functioning within the community, and that by employing the methods and procedures of group and family therapy the adolescent will have a reasonable chance of achieving this goal. Because each component of this model reciprocally influences all other components, the means employed to achieve a desired goal will influence not only the goal in question but also the tasks, working environment, and relationships involved. For example, if psychotherapy were the means used to help resolve a parent-child dispute about a school-based problem, then the formulation of the problem, goals to be achieved and tasks to be performed, etc., would be different from the formulation if, say, remedial education or spiritual counselling were the means used.

Goals

The end-point of the joint processes of working and being helped is the attainment of desired goals. As with the other components in this model, the goals chosen also reciprocally influence all preceding components. The concept of goals implies the notion of means and ends. The box in the diagram that contains "Goals" shows two kinds of goals: short-term goals and long-term goals. Because decisions have to be made about the means used to reach ends, the advantages and disadvantages of using means that attain short-term goals but hinder the attainment of long-term goals have to be carefully considered. It is, unfortunately, often tempting to use methods and procedures that provide immediate benefits to one of the participants when attempting to attain long-term goals. For example, a child-care counsellor may gain a short-term benefit by compelling an adolescent to do something, but at the "cost" of some trust or goodwill that may affect the willingness of the adolescent to collaborate in future endeavors. Thus it is important to ask questions such as: (a) what is more important in this situation, the short-term goals or the long-term goals?, (b) what are the best procedures and processes that can be used to attain these goals?, or (c) is there a way of achieving both short and long-term goals without compromising either? These questions raise issues that involve the processes of planning and anticipating.

French and Bell (1973), speaking from an organizational development perspective, cite Kast and Rosenzweig (1970) who illustrate the relation of planning and goals as follows:

> Basically, goals are plans expressed as results to be achieved. In this broad sense, goals include objectives, purposes, missions, deadlines, standards, targets, quotas, etc. Goals represent not only the end point of planning but the end toward which other managerial activities, such as organizing and controlling, are aimed. (p. 439)

In many situations, of course, there will not be any formal planning. In fact, one of the premises of grounded theory is that while BSPPs are goal directed, they are not necessarily overtly visible or consciously considered (Glaser & Strauss, 1967), which is why they have to be "discovered." This suggests that participants in a collaborative process should attempt to clearly and overtly state their goals at the beginning of their joint venture. Even if they are not immediately successful, attempting to do this will "sensitize" them to the process of planning. This, in turn, may facilitate more successful attempts later. Furthermore, if participants are able to formulate goals, and if they periodically re-assess these goals, they will be able to keep themselves "on course." As a result, they will be better able to collaborate effectively. This, in turn, will help them to maintain their working alliance.

In summary, it is hoped that it can be seen that the essence of the effective interaction between the two processes, working and being helped, is collaboration. To reach mutually desired goals, the participants must collaborate. There is a reciprocal interaction between the overall process of collaboration and whatever means are used to operationalize this process. In turn, both of these two components determine and are determined by three components: tasks, working environment and relationships. Lastly, all of these components are reciprocally affected by the desired goals. In concluding this chapter, it is hoped that this more formal substantive theory will be of practical service to those helping practitioners wanting to develop effective working groups where members can be helped to achieve their goals. It is hoped that by understanding the principles of collaboration contained within this model, practitioners will be able to make their collaborative efforts even more effective.

CHAPTER SEVEN

CONCLUSIONS AND DISCUSSION

Introduction

This chapter begins with a brief summary of the present study, followed by a discussion of some of its strengths and limitations. After a critique of the method used and an evaluation of the theories generated in this study, implications for research and practice are presented. The chapter closes with some concluding comments, including a quotation from an adolescent that illustrates, in a rather touching way, some of the benefits achievable when adolescents are able to do the work they need to do and to be helped in ways they require.

Summary of Study

Aims, Goals, and Research Questions

The initial aim of this research project was to develop a theory of adolescent residential treatment that would be based on the perceptions of adolescents who had demonstrated successful long-term outcome following the completion of an adolescent residential treatment program. To achieve this aim, the study began with two goals. The first goal was to answer two research questions: (a) what are the basic social psychological processes (BSPPs) occurring while adolescents are in residential treatment that are related to successful long-term outcome?, and (b) what are the key treatment ingredients that are involved in operationalizing these processes? The second goal of this study was to present the theory generated by this study in a manner which would be relevant to the day-to-day needs of staff working in an adolescent residential treatment center. To achieve these goals, and because of its potential value for discovering new information and generating new theory, even in familiar areas, grounded theory methodology was used in this study.

Grounded theory methodology anticipates that the initial aims, goals, and research questions will evolve or be refined during the course of a study (Sandelowski, Davis, & Harris, 1989; Strauss & Corbin, 1990). In the course of pursuing the original aim of this research project – the development of a theory of adolescent residential treatment – it was decided that broadening this aim somewhat could be useful. In response to incoming data that emphasized the themes of working and being helped, it was decided that instead of just aiming to develop a theory about adolescent residential treatment, the aim would be enlarged to allow for the development of a more generic theory of working and being helped. Doing this would mean that the theory generated in this study would not only be applicable to an adolescent residential treatment program but it could also apply to other settings where individuals are working and being helped by others.

While the initial goals of the study and the two research questions intended to help meet these goals remained the same throughout the course of the study, it soon became obvious after the project began that it would be difficult to answer the second research question precisely. Therefore, instead of immediately answering the question "what are the key treatment ingredients involved in operationalizing the BSPPs?" it appeared more useful to first address another question, namely, "what are the key components in the BSPPs?" Making this change was an acknowledgment that the precise explanation of how to operationalize the BSPPs at any one time would have meant moving towards providing explanatory "recipes." As the data of the study came in, attaining this level of precision did not seem possible. However, by determining the components of the BSPPs, it is believed that most of the groundwork required to answer the second research question has now been completed.

Findings and Results

The first research question. Based on the findings of this study, the answer to the first research question is that there are two BSPPs – **Doing Your Work** and **Being Helped** – that adolescents perceive as crucial to their long-term success. As a result of the discovery of these two BSPPs, two substantive theories directly applicable to adolescent residential treatment – one about "working" and the other about "being helped" – were developed.

The BSPP of Doing Your Work was identified as the central component in a substantive theory about "working" in an adolescent residential treatment center. "Working" here means engaging in a social psychological process in which social and psychological tasks and goals are accomplished and achieved, e.g., "getting better," "becoming normal," or "getting out." The adolescents interviewed for this study perceive that if adolescents are to benefit from being in the treatment program there are certain social and psychological tasks they need to accomplish. By working on these tasks over time they become engaged in the BSPP of Doing Your Work.

The BSPP of Doing Your Work involves both individual and group tasks. The comments of successful adolescents indicate they perceive that they must engage in those kind of tasks, e.g., telling others about their problems, that emphasize them as individuals working towards individual goals, as well as those kinds of tasks, e.g., becoming a working group, that emphasize them as members of a group of peers working towards common goals. In this study, the identification, description, and sequential arrangement of these tasks helped determine the stages and phases in the BSPP of Doing Your Work. In turn, this led to the development of a substantive theory of working in an adolescent residential treatment center.

The second BSPP identified in this study – Being Helped – became the central component in a substantive theory about "being helped" in an adolescent residential treatment center. This BSPP was perceived by the adolescents to be an interactive process whereby others (the adolescents' peers, staff, and families) helped them to complete the program and make the transition from the program back into the community. Description of the stages in this BSPP eventually led to the formulation of a substantive theory about being helped in an adolescent residential treatment program.

Although each of the two BSPPs identified in this study was seen as significant enough to both merit examination on its own and to be developed into a separate substantive theory, in reality both of these BSPPs are very much entwined. They also reciprocally affect each other, i.e. how adolescents are working affects how they can be helped and vice-versa. In the eyes of adolescents both of these BSPPs are crucial to long-term success. Both BSPPs must be engaged in if adolescents are to fully benefit from being in residential treatment. In short, adolescents must both do their work and be helped by others.

The second research question. If this study had only asked the first research question it would not be much more than a confirmatory study. Numerous other studies, as well as one's common sense, confirm that tasks must be performed and assistance must be provided in order to reach a goal. It was when the second research question began to be addressed that more useful information emerged. However, as was stated earlier, shortly after the study began it soon appeared useful to ask an additional question. Instead of just asking, "what are the ingredients needed to operationalize the unfolding BSPPs?" it also seemed useful to ask, "what are the important components in these BSPPs?"

The term "components" is used here at a higher conceptual level than the word "ingredients." Whereas the term "ingredients" is used to refer to the concrete behavioral constituents, e.g., "making eye contact," or "speaking in a firm voice," that comprise the clusters of behaviors used to operationalize a process, the term "components" refers to the more abstract labels that identify either clusters of behaviors or principles e.g., "opening up," "offering encouragement," that are used to operationalize a process.

Knowing the components in a process facilitates the management of that process, thereby facilitating the attainment of desired goals and the identification of the tasks necessary to achieve these goals. It also facilitates the identification of the resources that are needed to complete these tasks. In turn, knowing the goals to be achieved, the tasks to be performed, and the resources that are available assists in the selection or creation of the specific techniques (the "recipes") to accomplish these tasks. The "ingredients" that these recipes call for can then be chosen and combined to meet the requirements of the particular occasion.

A Theory of Working and Being Helped

Acknowledging that the two BSPPs are very much entwined, once the components of the two BSPPs discovered in this study were identified they were elevated to a higher conceptual level and integrated into a more formal substantive theory of working and being helped. Based on this theory a generic model of working and being helped was then developed. While this model is primarily used to achieve the second goal of this study, i.e., the development of a theory that is relevant in a practical way for those working with adolescents, it is also hoped that it will have applicability to other situations where the two generic processes of working and being helped are occurring. For example, it is hoped that a teacher helping a student to master some academic skills or a supervisor helping a group to work more effectively as a team may find the model useful.

The generic theory of working and being helped presented in this study suggests that most aspects of human enterprise involve two parties who are working towards goals and are being helped by each other to achieve these goals. Although one party may formally be designated as a helper, both parties have work to do and each party must be helped by the other party if they are to succeed. One of the central ideas in this theory is that the success of an enterprise depends upon the effective management of three key components: tasks, working environment, and working relationships. The information gathered in this study suggests that people need: (a) to learn what to do and how to do it, (b) to have an environment that will facilitate the process of doing it, and (c) to have a collaborative relationship that will provide the necessary help to accomplish the required tasks. All three components are crucial for long-term success. For example, even if the tasks are clear and the setting is suitable, the parties will not reach their goals if they cannot collaborate to their mutual satisfaction.

Strengths and Limitations of the Study

The Method

The present study used grounded theory methodology to guide the collection and analysis of data. Using the constant comparative method of analysis resulted in the generation of two substantive theories "grounded" in the data. Using the techniques of "reworking" and "rewriting," these two substantive theories were elevated to a more formal substantive theory. The strength of the grounded theory method is that it allows for the generation of theory that can be used to explain the phenomena in a particular setting. Because grounded theory is concerned with theory generation and not theory verification, its weakness is that its findings may not be applicable to other settings. This is even more true when one attempts to elevate a substantive theory to a formal theory. It is usually left to the reader to decide if the findings of a grounded theory study fit his or her own situation.

The Sample

A core group of seven adolescents provided the majority of the information for this study. This group consisted of adolescents who had successfully completed the program, had been living in the community for at least six months, and were considered to be successful not only by themselves, but also by people who knew them closely, e.g., their parents or past therapist. As such, these adolescents were assumed to be knowledgeable, at some level, about what adolescents have to do to succeed in the treatment program. It was also assumed that they would be able to supply useful information to people trying to help adolescents in a residential treatment center. These assumptions were verified in this study and a great deal of useful information was collected from these "informants."

Five other adolescents were also interviewed. Two of these adolescents were just completing the program. Exit interviews were conducted with each one of them for the purposes of theoretical sampling - to confirm and enrich categories already identified. Not only did they confirm the core categories, they were also able to embellish them in a way that the other adolescents could not (perhaps because of the passage of time since they had left the program). Thus, their interviews strengthened this study by confirming previous findings and by adding "the freshness of immediacy" to the findings.

Three adolescents who were not successful (at least according to the criteria of this study) were also interviewed. They were also interviewed for the purposes of theoretical sampling and in particular to determine if contrasting the experiences of unsuccessful adolescents with successful adolescents would yield any new information.

Interviewing these adolescents suggested that the core categories were not universally recognized and understood by all adolescents in the program. This strengthened the study by helping to define when and to whom the two BSPPs apply. However, a limitation of the study is that this boundary is not entirely clear yet. Another limitation of the study, illustrated by examining the sample, is that it does not clearly demonstrate the impact of the program over the long-term. For example, the three adolescents were considered failures according to the criteria used in this study, yet all claimed (to varying degrees) that the program had helped them. Does that mean that having been in the program will not benefit them over a longer term? It would appear from interviewing these adolescents that the determination of long-term success cannot be so black and white. For example, one of the adolescents deemed to be unsuccessful because she did not meet the criteria for success in this study was, at the time of her interview, gamely trying to succeed in the adult world. Although her longer term outcome at this time seemed uncertain, she displayed several encouraging signs. The other two adolescents were clearly "failures" at the time of their interviews. However, since their initial interviews they have been followed over the course of the research project. Both are now showing encouraging signs of recovery.

As an aside, it might be noted that all three of the adolescents deemed to be failures had extensive drug problems before and after the program. This suggests, very tentatively, that the impact of being in this treatment program is not enough sometimes to help an adolescent overcome a severe drug addiction problem. It also suggests that more resources may be needed to help adolescents with these kinds of problems.

Although using adolescents who can articulate their experiences of being in the program is consistent with grounded theory methodology, in this writer's opinion this is another possible weakness of the sample used in this study. This is because while observations of these articulate adolescents may hold true for other adolescents who are articulate, these observations may not hold true for less articulate adolescents. Perhaps adolescents with different cognitive abilities perceive the basic process they are to engage in differently, e.g., "pleasing adults."

The Researcher

Paradoxically, one of the strengths of this study as well as one of its limitations arose from the dual roles occupied by this writer. Throughout the course of this study, he functioned both in the role of researcher and in the role of an employee of the institution - i.e., the role of participant observer (Davis, 1986). As a person who was previously employed full-time by the institution which served as the research setting and who was still employed part-time while the study was conducted, this writer may have unknowingly encountered those problems associated with entrée to an institution by someone employed by the institution (Davis, 1986). While these problems were not perceived by this writer, it is possible that the adolescents might have seen him as aligned only with the staff of the RTC or other adults in the community. Consequently, there may have been an excessive need on the part of the adolescents who were interviewed to disguise or hide their true sentiments, or to please or displease the researcher, which, in turn, might have distorted the findings of this study. However, this seems unlikely since all but two of the adolescents had been out of the program for at least six months and there was no obvious reason for them to behave this way. In fact, most of the adolescents seemed very pleased to be asked to give their reactions to being in the program and to bring the researcher up to date on what was happening in their lives. Furthermore, as an aside, because these interviews seemed to be so useful, there is some discussion about making exit and follow-up interviews a routine procedure of the program.

However, despite whatever disadvantages may have existed by functioning in this dual role, it is believed that they were outweighed by the advantages, as others have also noted (Davis, 1986). Procedures and routines of the treatment setting were already understood. Therefore the adolescents' references to the program were quickly grasped by the researcher. Perhaps most important, though, the "guardedness" many of these adolescents have for adults appeared to be absent. With one possible exception, rapport was quickly and easily established, particularly so with all of the adolescents who are now doing well. However, in future studies it would be instructive to learn what kinds of responses would be obtained by researchers who were previously unknown to the adolescents.

Evaluation of the Theories

As grounded theory methodology is a variant of qualitative research methodology (Strauss & Corbin, 1990), two sources exist for criteria used to evaluate the two substantive theories and the one more formal substantive theory generated in this study. The first source of criteria comes from those researchers who see themselves as doing qualitative research, whether or not they are using the grounded theory method specifically (e.g., Lincoln & Guba, 1985). The second source of criteria comes specifically from grounded theory methodologists (e.g., Glaser, 1978).

Turning first to the qualitative researchers, Hutchinson (1988), following the writings of Kuhn (1970), states that "grounded theory research strives to be paradigm-transcending" (p. 123). Other writers (Lincoln & Guba, 1985) have also expressed similar sentiments about the qualitative or naturalistic research approaches in general. One of the reasons these authors do this is because they believe the fundamental premises upon which these research approaches rest are radically different than those of the quantitative or traditional research approaches. Consequently one would expect the criteria used for evaluating a study in the one paradigm to be different from the criteria used in the other paradigm. However, for a variety of reasons (including practical reasons like promoting understanding between the two approaches), the criteria for evaluating qualitative research are often stated in "analogous" or "companion" terms to the more widely known terms used in traditional research (Lincoln & Guba, 1986). While understandable, this strategy runs the risk of creating more confusion and limiting the power of the qualitative research paradigm. For example, if grounded theorists believe that "truth" in human arenas is relative and not absolute in the positivist sense, then why talk about "truth value" (Lincoln & Guba, 1985)? Might it not be better to focus on "meaning" (Eisner, 1981)?

However, although there are indications of change (Lincoln & Guba, 1986), it seems that at the present time the criteria for evaluating a qualitative or naturalistic study (including grounded theory) are still based on terms deemed analogous to traditional criteria. Consequently discussions of grounded theory research invariably make reference to such terms as validity and reliability (Hutchinson, 1988, Rennie et al., 1988, Quartaro, 1986). Acknowledging that this is the prevailing practice, the present study will also follow this approach. When evaluating a theory, whether taking a qualitative or a quantitative approach, one of the first issues to be determined is: how rigorous is the theory? This is generally determined by demonstrating the trustworthiness of the findings upon which the theory is based.

Trustworthiness

Lincoln & Guba (1985) state that, conventionally, inquirers have tried to address four issues that affect trustworthiness: (a) truth value, (b) applicability, (c) consistency, and (d) neutrality. The questions which naturally flow from these issues are:

(1) "Truth value": How can one establish confidence in the "truth" of the findings of a particular inquiry for the subjects (respondents) with which

and the context in which the inquiry was carried out?

(2) Applicability: How can one determine the extent to which the findings of a particular inquiry have applicability in other contexts or with other subjects (respondents)?

(3) Consistency: How can one determine whether the findings of an inquiry would be repeated if the inquiry were replicated within the same (or similar) context?

(4) Neutrality: How can one establish the degree to which the findings of an inquiry are determined by the subjects (respondents) and conditions of the inquiry and not by the biases, motivations, interests, or perspectives of the inquirer? (Lincoln & Guba, 1985, p. 240).

Inquirers using traditional research methods responded to these issues by developing the familiar criteria known as "internal validity", "external validity," "reliability," and "objectivity" (Cook & Campbell, 1979). Following their lead, researchers using qualitative or naturalistic research paradigms developed analogous terms which address these issues from their point of view.

The analogous term for internal validity is credibility. The critical question here is: will readers of this study find the researcher's analysis, formulations and interpretations believable (credible)?

In the present study, the findings were made available to some of the adolescents who had participated in the study as well as to some of the staff in the research setting. Their responses to this question were very favourable. However, since there are plans to soon have more adolescents and other staff examine and assess these findings, further determination of the credibility of this study will have to await their judgements. When the results of this study are available to a larger group of adolescents and staff their responses should allow this issue to be resolved.

The analogous term to external validity is transferability. Naturalistic inquirers are cautious about generalizing their findings to other persons or settings. Instead they prefer to provide enough details in their description that readers are presented with a "thick description" of the settings, persons and events under study (Denzin, 1989; Lincoln & Guba, 1985). Doing this enables the reader of the study to determine if the findings have applicability to his or her situation.

In this study, in an attempt to stay as close as possible to the adolescents' accounts of their own experiences, and in the interests of brevity, only limited information was provided about the setting and persons. The focus was on the events, specifically those events that comprised the basic psychosocial processes as they unfolded in the research setting. Consequently, it is quite possible that there is not enough information for those readers outside this setting to determine whether their situation is or is not analogous to the situation in the present study.

Dependability is the analogous term for reliability. However, rather than emphasizing replicability as is conventionally done, in qualitative research the emphasis is on stability. Since naturalistic inquiry involves emergent designs, exact replications of studies are unlikely. However the development of an "audit trail" (Halpern, 1983) enables others to follow the "methodological steps" of the researchers. As indicated earlier in chapter 3 access to all the data in both its raw and processed stages is available to appropriate parties.

The analogous term for objectivity is confirmability. Here the emphasis is on the confirmability of the data, rather than on intersubjective agreement. Naturalistic inquiry stresses (as was done in this study) the keeping of memos which document the basis and evolution of the researcher's conceptual process, enabling other researchers to follow and, if need be, challenge the inquirer's assumptions, biases, or prejudices about the context or problem under study. Again, as noted above, access to the memos of this study is possible.

In summary, there is support for the notion that there is trustworthiness in the findings of this study and that the study was conducted in a rigorous manner. This lends weight to the assertion that the three theories generated from this study do have credibility. However, it must be emphasized again that the primary purpose of this study was one of discovery, not verification. For this study, theory generation was viewed as more important than theory verification.

Density and Clarity

The other source of criteria against which to evaluate the theories emerging from this study are those specifically emanating from grounded theory methodology. To determine the applicability of a grounded theory to any phenomena, a good grounded theory should be: (a) dense, in terms of meaning, and (b) clear, in terms of presentation (May, 1986).

Three aspects of density were discussed earlier in chapter three. The first two aspects discussed were scope and complexity. These aspects referred to the breadth and depth of a theory. The third aspect, integration, referred to the "tightness" of the conceptual framework.

The two substantive theories appear to be dense in some ways but not in others. It appears that most of the concepts having to do with the central processes in each theory have been discovered. This was demonstrated when additional interviews did not reveal new categories of any significance. Therefore the scope of these two theories seems adequate. However the depth of categories is not entirely adequate. More examples of the properties of many of the concepts would have been useful. In part, this was due to the difficulty of getting the adolescents to draw finer distinctions about their experiences. For example, while adolescents were able to identify a concept, e.g., being helped, they often had trouble describing the finer aspects of a concept, as the following quotation shows.

* * *

R: When I've talked with other kids they've mentioned "being helped." It's kind of one the main things that seems to happen around here. Does that seem true for you?
Cl: Yes it does.
R: When you remember [the program] do you think of that notion of "being helped"?
Cl: Yeah, a lot.
R: Is there anything else that you can add to that, the notion of "being helped"? (pause) If you can, if you can't, that's fine.
Cl: Mmmm, no.

* * *

As an aside, it might be noted that this portion of the transcript also demonstrates the necessity of a researcher doing grounded theory research to have fairly sophisticated interviewing skills. As the quotation above illustrates, it is important to phrase the questions one asks adolescents very carefully, something that is not so easy to do spontaneously. After reflecting upon this segment of the transcript it seems likely that asking more focused or more direct questions also would have been useful.

Integration, the last dimension of density, is more of a concern at the level of formal theory than at the level of substantive theory. Glaser (1978) says integration at the substantive level tends to happen naturally as the data in the substantive area emerge. However, at the formal level, he says "substantive integration is likely to disappear along with fall-out [dropping of substantive codes], condensing [subsuming them into higher order conceptual categories], and depyramiding of substantive codes" (p. 154). Consequently, it is often difficult to be certain that the integration of a formal theory is nothing more than a logical elaboration and therefore an integration that is unsupported by the data. Because the more formal substantive theory of this study did not examine other substantive theories intensively, it is vulnerable to this charge. However, because the concepts comprising the more formal substantive theory were found elsewhere in the professional literature, there is some support for the assertion that the integration of the more formal substantive theory is more than just a logical elaboration.

There is another issue involved when a theory is elevated from a substantive level to a more formal level. When looking at the three theories of this study, it can be seen that as the two substantive theories were integrated and elevated to a more formal level, the resulting theory gained in scope but lost in complexity. Glaser (1978) describes this by saying "formal theory is extensive compared to the intensiveness of substantive theory" (p. 153).

After a theory is evaluated for density, it can be evaluated for clarity. Glaser (1978) says that grounded theories should have "grab," meaning they should be interesting, memorable, and useful. To judge the applicability of a grounded theory to a phenomenon and enable a reader to determine its clarity of presentation, the four criteria discussed earlier in chapter three are used. A good theory must: (a) have fit, (b) work (c) have relevance, and (d) be modifiable.

If a theory has fit it means that the categories of the theory fit the data. This means that the data were not forced into pre-conceived or pre-existing categories. A useful test for fit is the reaction of the participants (May, 1986). In the present study, the reaction from the participants who have responded so far is that the theories do make sense. According to them, the concepts discovered in this study seem to fit their experiences.

The word "work" is used differently in grounded theory terminology than in this study. If a grounded theory works, it means it is able "to explain what has happened, predict what will happen and interpret what is happening in an area of substantive or formal inquiry" (Glaser, 1978, p. 4). A theory works if it can get to the core of what is going on in a substantive setting.

If the theory works, it is likely that it is has relevance. This means it has "allowed core problems and processes to emerge" (Glaser, 1978 p. 5). As was the case with the criterion of fit, whether or not the theories have met the criteria of work and relevance depends upon the reactions of participants in the study. They will be able to say whether they think the theories explain what has happened.

Again, based on the reactions of those who have responded thus far, it appears that the theories in the present study work and have relevance. However, future reactions of staff and other adolescents to these theories, as well as the testing of hypotheses generated from these theories, will better enable the relevance and predictive value of the theories to be determined.

The last criterion for assessing the value of a grounded theory is modifiability. When new data are acquired, for example information about a new condition affecting a BSPP, the theory should be able to accommodate this new information. The new information should just make the theory denser or richer. This criterion can only be really assessed as time goes on. Certainly the theories seem to have adequately captured the data to date. Whether they can incorporate new data as easily remains to be seen.

Implications for Research and Practice

Implications for Research

As this study was concerned with theory generation, the major implications for research arising from it concern the elaboration and verification of the concepts and premises which it identifies. Future work could include selecting a component of the theory, e.g., "Feeling ready to leave" for a more detailed investigation. Methods allowing for more precision of explanation and more generalizability of results could then be used to elaborate and verify aspects of these concepts, e.g., the methods adolescents use to determine their readiness for discharge.

Future work verifying hypotheses based on the concepts or premises of selected components of the three theories also would be useful. It seems possible that several hypotheses could be developed and tested for verification.

Without meaning to limit the generation of these hypotheses, some possibilities are:

1. Most adolescents in this program will perceive that there are two fundamental processes - Doing Your Work and Being Helped - in which they need to engage if they are to attain successful long-term outcome.

2. Adolescents in other RTCs will perceive that there are two fundamental processes - Doing Your Work and Being Helped - in which they will need to engage if they are to attain long-term benefit from being in a residential treatment program.

3. Three kinds of fundamental relationships exist within an adolescent treatment program: (a) transference relationships, (b) working alliances, and (c) real relationships.

4. The development of a strong working alliance is the most crucial factor affecting an adolescent's ability to work effectively in the treatment program.

5. The presence of a strong working alliance is the most crucial factor affecting positive long-term outcome.

6. Adolescents who develop a strong relationship with a staff member, whether it be a transference relationship, a working relationship or a real relationship, will be better able to withstand the stresses of a treatment program than adolescents who do not develop such a relationship.

7. Adolescents who develop a strong relationship with a staff member, whether it be a transference relationship, a working relationship or a real relationship, will benefit more from being in a treatment program if that relationship is managed properly by staff than adolescents who do not develop any kind of relationship with staff. Conversely, adolescents who develop a strong relationship with a staff member will be more adversely affected if this relationship is not managed properly (by staff) than adolescents who do not develop any kind of relationships with a staff member.

8. Adolescents who are told the tasks they are expected to accomplish will benefit less from being in a treatment program than adolescents who are encouraged to use the resources of the program to determine what their particular goals should be.

9. Adolescents who have more control over the creation and maintenance of their environment will exhibit less anxiety and a greater degree of involvement in a treatment program than adolescents who do not have such control.

10. Adolescents who have more involvement and more influence in the planning of their own transition from a residential treatment program back to their community will attain better outcome results than adolescents who do not have this involvement and participation.

Implications for Practice

Based on the findings of this study, two major implications for practice arise. The first concerns the nature of the relationships between the adolescents and staff. The findings of this study lend support to the aggregate of findings in the literature that stress the importance of the therapeutic working alliance and the necessity of some "realness" in the relationship between helper and helpee. As the treatment program under study emphasizes the evocation and working through of the transference relationship, the question arises of how to appropriately balance the competing needs represented by each of these kinds of relationship. Adolescents are still developing and therefore have genuine needs for role-models. They also have needs for validation by adults. These needs for role-models, for validation and for everyday social interaction are not necessarily neurotic needs that ought to be worked through. To meet these needs, adolescents need real and ongoing involvement with adults. This notion was supported by the adolescents in this study. Perhaps because staff were more formal when adolescents and staff were "working," it appeared that adolescents used the more informal times (e.g., recreational activities or household tasks involving both adolescents and staff) to evaluate the "realness" of the relationships.

How then is one to balance the need to address age-appropriate developmental issues with the competing need to work through the traumas of past relationships? Questions also arise about how both care-staff and therapists should handle transference issues. For example:

1. When issues of transference are involved should the role of care-staff be different than the role of therapists?

2. Should care-staff seek to defuse transference issues, e.g., "I don't care if I remind you of your mother, we need to get the dishes done now!", while therapists seek to evoke and intensify these issues, e.g., "So, can you put into words the feelings you have towards me now?"

3. Should therapists be neutral referees who seek to help both care-staff and adolescents resolve their transference and countertransference issues so that care-staff and adolescents can work towards more real relationships?

4. Should the therapists act like family therapists, i.e., behave "warmly" towards the adolescents while both seeking to direct affective concerns towards the people who "really" count, and seeking to avoid becoming enmeshed in transference issues? Or should they act like classical analysts, i.e., remain neutral towards the adolescents while seeking to evoke their repressed feelings from unresolved psychic conflicts?

The second implication for practice arising from this study has to do with the attainment of long-term goals. If staff hope to assist adolescents to achieve long-term success, it seems crucial to provide more assistance to them as they make the transition from the program back into the community. This issue was alluded to earlier in Chapter 4 under the heading of "providing a context of continuity of support." Most of the successful adolescents reported having difficulty making the transition. It seems even more likely that this is also the situation for adolescents who are unsuccessful. One wonders to what degree adolescents with unfavourable outcomes are affected by such factors as "having difficulties in transition" or "losing support after leaving the program." Other questions also arise such as: (a) are adolescents with unfavourable outcomes doomed to failure regardless of the type of ongoing support they receive, or (b) are there specific kinds of support adolescents must have to make the transition from program to community, or (c) can preventive work be done while adolescents are still in the program that will "stressproof" them when they return to the community?

Concluding Comments

This study has emphasized the importance of two concepts - working and being helped - for the long-term success of adolescents in a residential treatment program. The importance of "doing your work" has been stressed repeatedly. To ensure long term success, it was emphasized that adolescents must determine the goals they need to achieve and the unique tasks required to achieve these goals. It was also emphasized that to succeed in achieving these goals adolescents must perceive they are being helped by others. In short, each adolescent in the program must do his or her work and each must be helped. However, as was stated earlier in this study, the notion of doing your work and being helped in the program involves something of a paradox. While working in the psychotherapeutic sense often implies moving forwards and accomplishing age-appropriate developmental tasks, sometimes one has to proceed in a seemingly paradoxical way. Sometimes one has to "go backwards to go forward." Another way of describing this paradox is to say, "the best form of work is play." Similarly, when a helper thinks of helping, he or she usually thinks of taking an active stance, of doing something. However, sometimes the best way of helping is by letting be. In closing this chapter, the paradox of working and being helped in the program cannot be better illustrated than by presenting the following quotation, and in so doing, letting the adolescents (as they should) have the last word.

> R: O.K. Is there anything about let's say the food, the teddy bears, or groups, or school, any particular elements about the program, special groups or special activities, or Dr. B, or anything like that we haven't mentioned that you'd like to discuss? Tell me your impression if it stands out for you.
>
> Cl: I guess teddy bears.
>
> R: O.K. tell me about teddy bears.
>
> Cl: When I first came they gave me a teddy bear and I thought they were really nuts, and you know "I'm almost sixteen years old here, and don't give me a teddy bear." But I had lost my childhood to all the pain around me, you know my father stole my childhood from me, from his drinking, and my mom's drinking. I had to be an adult. I had to grow up so fast, and I lost my childhood, and that's something that [the program] gives back to you. Not by giving you a teddy bear, you know, that does help because I didn't get enough teddy bears when I was a little girl, but I never got to play on the playground. I never got to be free-spirited, and no troubles and you know, just laugh freely, and just run around, and feel like a little girl. That's something that [the program] gives you. They let you be a. . . you know, if you want to be a little kid you can be one. If you know if you want to feel. . . you know if you need to be a baby you can have a bottle if you want. You can be whatever you want to be here. If you lost your childhood you can have it back, which is really glad because now I know how to have fun, and I know how to let go once in a while and just have fun. Sometimes when I look at my teddy bears sitting at home (even though I think they're ugly) it reminds me that I maybe need to go to the park and go swing on the swings or something. Just be that little girl lost in me that I wanted to be, but I couldn't be it because I had to take care of my dad and my brother.

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Appendix

University of Alberta
Faculty of Graduate Studies

INFORMED CONSENT FORM

Subject Title: Adolescent Residential Treatment
Investigator: Dennis Brown 492-5245

The purpose of this research is to increase understanding of adolescent residential treatment. Information about this treatment will be obtained by interviewing those who have been directly or indirectly involved in the treatment process, especially the adolescents themselves. During these interviews, questions about personal attitudes, observations, feelings and experiences will be asked. Interviews will be audiotaped.

Although there may be no direct benefits to the participants of this study, it is hoped that the information they share will be helpful to other clients and helping professionals.

THIS IS TO CERTIFY THAT I, ______________________________, HEREBY agree to a) participate as a volunteer in the above named research study; b) allow my child ______________________________ to participate in the above named research study.

I understand that there will be no intended health risks to me or my child, resulting from our participation in this research.

I hereby give my permission for me or my child to be interviewed and for the interviews to be audio-taped and subsequently transcribed into written form using a pseudonym.

I understand that at the completion of the research the tapes will be erased. I understand that the information may be published, but neither my name nor my child's will be associated with the research.

I understand that either I or my child is free to withdraw our consent and terminate our participation at any time, without penalty.

I have been given the opportunity to ask whatever questions I desire, and all questions have been answered to my satisfaction.

______________________________ Participant

______________________________ Researcher

______________________________ Date